A Comparative analysis of HIV serostatus disclosure pattern among men and women in Gaborone City Council, Botswana

by

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Declaration

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the

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Date: March 2013

Abstract

Disclosure of HIV status is an integral part of HIV prevention and care programmes. It plays a key role in adherence to antiretroviral therapy. It is a vital component of voluntary counselling and testing which is the gateway to HIV prevention, care and access to anti-retroviral treatment. The aim of this study was to compare the pattern of HIV-status disclosure among men and women respectively as well as to evaluate the factors that influenced HIV-status disclosure among these groups.

A sample of 74 participants from four Infectious Disease Control Clinics located in Gaborone, Botswana completed self-administered questionnaires. The contents of the questionnaire addressed issues around knowledge and attitude towards disclosure, timing of disclosure and to whom, reasons for disclosure or non-disclosure, barriers to disclosure and consequences of disclosure.

The study found that the majority of respondents had disclosed their HIV-status. Disclosure was more common among older participants for both men and women. In most scenarios presented to respondents, women were more willing than men to disclose their HIV status. However, men were more willing to disclose their status if they were e.g. faced with situations in which they were seriously ill, where their peers or friends were also willing to disclose their status or in cases where they would not be able to keep their hospital visits secret.

Further research is needed on disclosure pattern among both males and females of low and high socio-economic status. The study recommended that the subject of disclosure should be introduced into routine HIV/AIDS improvement monitoring parameters.

Opsomming

Openbaarmaking van MIV-status is ‘n integrale deel van MIV-voorkomings en versorgingsprogramme. Dit speel ‘n sleutelrol wat betref die nakoming van anti-retrovirale terapie. Dit is ‘n noodsaaklike komponent van vrywillige berading en toetsing wat die weg aandui tot MIV-voorkoming, sorg en toegang tot anti-retrovirale behandeling. Die doel van hierdie studie was om die patroon van MIV-status-openbaarmaking onder mans en vroue respektiewelik te vergelyk, asook om die faktore wat MIV-status-openbaarmaking in hierdie groepe beïnvloed, te evalueer.

‘n Monster van 74 deelnemers van vier Aansteeklike Siektesbeheerklinieke in Gaberone, Botswana, het selfgeadministreerde vraelyste voltooi. Die inhoud van dié vraelyste was gerig op aangeleenthede rondom kennis en ingesteldheid teenoor openbaarmaking, die tydsberekening vir openbaarmaking en teenoor wie, redes vir openbaarmaking of nie-openbaarmaking, hindernisse rondom openbaarmaking en gevolge van openbaarmaking.

Die studie het bevind dat die vlak van bewustheid oor MIV/VIGS laer onder mans as vroue was. Die meerderheid respondente het hulle MIV-status openbaar gemaak. Openbaarmaking het meer algemeen onder ouer deelnemers, mans sowel as vrouens, voorgekom. In die meeste scenarios wat aan respondent voorgelê is, het vroue groter bereidwilligheid as mans getoon om hulle MIV-status openbaar te maak. Mans was egter meer gewillig om hulle MIV-status openbaar te maak in gevalle waar hul met situasies te make gehad het dat hulle ernstig siek is, waar hulle eweknieë of vriende ook bereid was om hulle status openbaar te maak, of in gevalle waar dit nie vir hulle moontlik sou wees om hulle hospitaalbesoeke geheim te hou nie.

Nog navorsing oor openbaarmakingspatrone is onder mans en vroue van lae en hoë sosio-ekonomiese status nodig. Die studie beveel aan dat die onderwerp van openbaarmaking by roetine MIV/VIGS-verbeteringsmoniteringsparameters ingesluit behoort te word.

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Dedication

This project is written in memory of my late grandmother, Mrs Taiwo Akanke Akinyemi who brought me up and gave me tender motherly care. I also dedicate this study to my wife for her encouragement and motivation.

Acronyms

AIDS: Acquired Immunodeficiency Syndrome

ART: Antiretroviral Therapy

ARV: Antiretroviral Drug

BDS: Botswana Demographic Survey

CDC: Centers for Disease Control and Prevention

CHANGE: Center for Health and Gender Equity

FHC: Family Health Company

GCC: Gaborone City Council

GDHMT: Gaborone District Health Management Team

GoB: Government of Botswana

HAART: Highly Active Antiretroviral Therapy

HCP: Health Care Provider

HCW: Health Care Worker

HIV: Human Immunodeficiency Virus

HRDC/HRU: Health Research Development Committee/Health Research Unit

MoH: Ministry of Health

MSM: Men who have Sex with Men

NACA: National AIDS Coordinating Agency

PLWHA: People Living With HIV/AIDS

PSI: Population Services International

STI: Sexually Transmitted Infection

UN: United Nations

UNAIDS: The Joint United Nations Programme on HIV/AIDS

UNFPA: United Nations Population Fund

US(A): United States (of America)

WHO: World Health Organization

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Chapter 1: Introduction

Chapter 1 discusses the epidemiology of HIV/AIDS globally, in sub-Sahara Africa and with emphasis on Botswana. HIV among men and women is also discussed. Then, the rationale for conducting the study follows.

The research question, aim of the study, objectives of the research, and significance of the study are also included in this chapter.

1.1 Background Information

1.1.1 The global HIV epidemiology

According to the UNAIDS global epidemic record of 2012, 34.0 million people were living with HIV at the end of 2011. About 0.8% of adults aged 15-49 years are living with HIV globally. Sub-Sahara Africa is still the most severely affected with an estimate of 1 in every 20 adults (4.9%) living with HIV. This also accounts for 69% of people living with HIV globally. Next to sub-Sahara Africa is Caribbean, Eastern Europe and Central Asia.

Generally, there is decline in new infection in 2011. An estimated new infections in 2011 was 2.5 million which was 20% lower than 2001 estimate and the sharpest decline was recorded in Caribbean (42%) followed by sub-Sahara Africa (25%). Contrary to the decline in Caribbean and sub-Sahara Africa, the trend of new infection has increased to 35% (27,000 to 37,000) in Middle East and North Africa between 2001 and 2011 (UNAIDS, 2012). The incidence of HIV infection in Eastern Europe and Central Asia is also on the increase since the 2000s having being relatively stable for many years (UNAIDS 2012).

In 2011, 1.7 million people worldwide died from AIDS-related causes which represent a 24% decline in AIDS-related deaths compared with 2005 when 2.3 million deaths were recorded (UNAIDS, 2012).

1.1.2 The sub-Saharan HIV epidemiology

Sub-Sahara Africa remains the most severely affected region accounting for 69% of people living with HIV worldwide and the regional prevalence of HIV infection in this region is nearly 25 times than in Asia. Also, 23.5 million people were living with HIV in Sub-Sahara Africa at the end of 2011 (UNAIDS, 2012).

Mortality due to AIDS-related causes has declined in the region; 1.7 million AIDS-related deaths were recorded in 2011. This represents a decline of 32% from 2005 to 2011. Despite the decline, the region still accounted for 70% of all the people dying from AIDS IN 2011 (UNAIDS, 2012).

Since 1995, antiretroviral therapy has saved 9 million life-years in sub-Sahara Africa. The region also experienced accelerated health gains with the number of life-years saved by antiretroviral therapy quadrupling in the last four years. The experience in KwaZulu Natal, a hyper-endemic province in South Africa demonstrates the macroeconomic and household livelihood benefits of expanded treatment access resulting in increasing employment prospects among individuals receiving antiretroviral therapy (UNAIDS,2012).

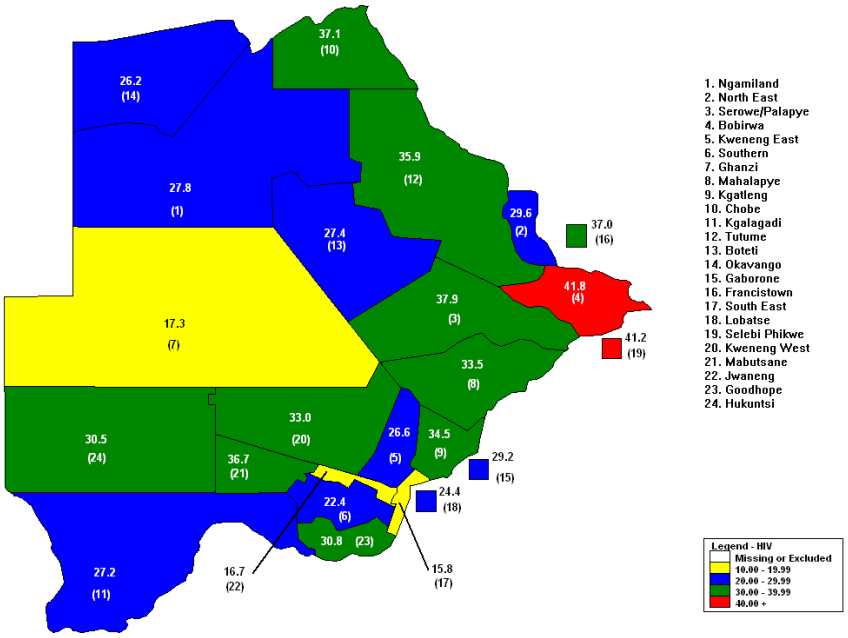
1.1.3 The Botswana HIV epidemiology

HIV/AIDS is still a great challenge in Botswana despite collaboration and spirited efforts channeled to prevention campaigns. According to the Botswana AIDS Impact Survey III (BAIS III), 17.6% of the population aged 18 months and above was HIV infected in 2008 compare to 17.1% in 2004 (UNAIDS, 2012).

The HIV prevalence rate for females was 20.4% compare to 14.2% in males. The incidence rate also shows gender disparity where the incidence is higher in females than males (Botswana AIDS Impact Survey III, 2008). According to the Botswana AIDS Impact Survey III, the HIV prevalence is higher in urban areas compare to rural areas. The urban areas had HIV prevalence rate of 19.1% compare to 17.1% for rural areas.

Bobirwa and Selebe Phikwe recorded the highest HIV prevalence rates of 41.8% and 41.2% respectively. The lowest HIV prevalence was recorded in South East standing at 15.8% (UNAIDS, 2012). Gaborone is the capital city of Botswana and located in the South Eastern district of the country. It is the study location for this project and falls within the district (South East) with the lowest HIV prevalence. The figure below shows the geographical distribution of HIV prevalence in Botswana.

Figure 1: Geographical distribution of HIV prevalence in Botswana



Source: 2011 Sentinel Surveillance Report

The 2011 Ministry of Health ANC Surveillance report stated that the HIV prevalence among adults aged 15-49 years in Botswana was found to be 25% while the prevalence among pregnant women was estimated at 30.4%. It was also reported that HIV prevalence among the pregnant women aged 15-49 years attending antenatal clinic has been declining over the years. It had declined from 37.4% in 2003 to 30.4% in 2011. The HIV prevalence increases gradually with age. HIV prevalence was lowest (10%) among the 15-19 year age group and highest in the age group of 35-39 years (52.3%).

1.1.4 Men and HIV

The first AIDS case was reported in 1980 and HIV infection was predominantly among men who have sex with men (MSM) (WHO, 2003). The prevalence of HIV infection is higher among men who have sex with men than the other men populace. Likewise, the HIV prevalence among men who have sex with men in capital cities is consistently higher than in the general population. The prevalence of HIV infection among men who have sex with men in surveys in capital cities is on average 13 times higher than that in country's general population (UNAIDS, 2012).

Studies show that male circumcision reduces the likelihood that men will acquire HIV infection from a female partner. WHO and UNAIDS therefore recommended voluntary medical male circumcision in countries with high rates of HIV infection and low rates of male circumcision (UNAIDS, 2012).

1.1.5 Women and HIV

Women represent 49% of adults living with HIV worldwide and HIV/AIDS is the leading cause of death in women of reproductive age (15-49 years). In sub-Sahara Africa, women constitute 58% of all people living with HIV. Also, among young people aged 15-24, the HIV prevalence rate for young women is twice that of young men (UNAIDS World AIDS Day Report, 2012).

Women Out Loud- UNAIDS 2012 publication stated that each minute, one young woman is infected by HIV and female sex workers are 13.5 times more likely to be living with HIV than other women.

Women are also more vulnerable to HIV infection than men because of gender inequality, socio-cultural factors, low literacy level and economic deprivation. Sexual transmission is still the dominant mode of infection in women (UNAIDS, 2012).

1.1.6 Key drivers of HIV epidemic in Botswana

Multiple and concurrent sexual partnership: in contrast to culturally permitted polygamy, multiple concurrent sexual partnerships are a tolerated pattern of sexual relationship in sub-Sahara Africa (UNAIDS, 2012). According to Botswana AIDS Impact Survey III, 21% of males are reportedly having sex with more than one sexual partner in the 12 months preceding the survey compare to 2.3% of females. HIV prevalence among persons reporting multiple sexual partnerships was 16% for males and 34% for females.

Adolescent and intergenerational sex: most young boys and girls are attracted to older sexual partners because of the monetary gains and material support they receive from these older men and women who may be old enough to be their fathers or mothers. Early exposure to older men or women with longer sexual history are considered to have accounted for higher infections among adolescents most especially girls, thereby bringing into play intergenerational sexual intercourse as a significant driver of HIV epidemic (UNAIDS, 2012).

Alcohol and high-risk sex: studies report alcohol consumption to be associated with increased risk of contracting HIV, gender violence, risky sexual behaviors and non-adherence to AIDS treatment for both men and women. The Botswana AIDS Impact

Survey III reported that 37.4% of the population aged 10-60 years admitted ever taking alcohol, 48.9% males and 27.7% females. The majority 62.7% had been intoxicated at least once in the 4 weeks preceding the survey.

Stigma and discrimination: it encourages the spread of HIV infection by preventing individuals from going for voluntary counseling and testing, practicing safe sexual behavior and utilizing available health services and products. According to a study carried out in 5 Southern African countries (Botswana, Mozambique, Lesotho, South Africa and Swaziland) Botswana was cited as one of the most visible Positive Health Dignity and Prevention Strategy 2010-2016 (UNAIDS, 2012).

Gender violence and sexual abuse: according to Gender based Violence Indicators Botswana, almost 70% of people interviewed had experienced gender based violence at least once in their lifetime and nearly 30% over the last year. Women are at higher risk of HIV infection because of the combination of social acceptance of male partners having more than one sexual relationship and biologically due to the anatomical nature of their sexual organ (Strebel, 1993).

1.2 Rationale of the Study

The Botswana government, together with non-governmental organizations and donor agencies have raised the level of awareness among the citizens and aim to stop the spread of HIV by year 2016 (Bana, 2011). Despite the level of awareness through the media, voluntary counseling and testing unit in ARV clinics and prevention of mother to child transmission programmes, only about 31.6% of pregnant women disclosed their status to their partners after eight months of testing and counselling (Medley et al, 2004). This put the partners at a greater risk of being infected with HIV.

The prevalence of HIV/AIDS in Botswana is higher among women than men. About 300,000 adults aged 15 years and above are living with HIV in Botswana of which 130.000 and 170,000 are men and women respectively (UNAIDS, 2010). Could this

mean that women disclose more than men and that poor disclosure in men may indirectly make women more vulnerable to HIV infection?

Disclosure is an integral part of HIV prevention and care programmes. It plays a key role in adherence to antiretroviral therapy (ART). It is a vital component of voluntary counseling and testing (VCT) which is the gateway to HIV prevention, care and access to anti-retroviral (ARV) treatment (Nieburg, 2005)

The extent to which disclosure occurs depends on the social, cultural, belief and economic factors /circumstances faced by the person living with HIV/AIDS. The stigma and discrimination (rejection, abandonment, accusation of infidelity and domestic violence) emanating from these factors further reinforce non-disclosure.

Disclosure can be categorized into three groups: full disclosure (before sex), delayed disclosure (after sex) and non-disclosure. Many studies have been conducted on disclosure among women especially pregnant women attending anti-natal clinics and the general population involving both men and women but little has been done to compare disclosure patterns among men and women (Issiaka et al, 2001). If the factors responsible for disclosure and non-disclosure are identified, positive attitude towards disclosure can be reinforced through modified and comprehensive counseling.

1.3 The Research Question

The study was conducted to compare the disclosure pattern of HIV status among men and women.

The research question that was analyzed is:

What are the factors responsible for differential disclosure and non-disclosure among men and women?

1.4 The Aim and Objectives of the Study

The aim of the study was to compare the patterns of HIV-serostatus disclosure among men and women.

The objectives of the study were:

- To determine the factors that influence HIV-serostatus disclosure by men and women disclosure
- To find measures that can be used to break the gender differences in HIV-serostatus disclosure among men and women
- To compare and contrast the outcomes with results from other developing countries
- To suggest to the authority concerned to incorporate the recommendations based on the findings into the HIV pre and posttest counseling services/programmes

1.5 Significance of the Study

The study will compare and analyze the pattern of HIV-serostatus disclosure among men and women. The factors favoring disclosure and those preventing disclosure will be identified and these will be used to further reinforce the existing pre and posttest counseling guidelines.

The study findings could be important to a number of stakeholders that include Gaborone District Health Management Team (GDHMT), the HIV/AIDS Prevention Division of the Botswana Ministry of Health, the body of knowledge at Stellenbosch University, and the fraternity of medical staff in Botswana and beyond and finally those who are affected and infected with HIV and AIDS.

Chapter 2: Literature Review

Chapter 2 contains the review of literature. Meaning of disclosure, disclosure and legal issues, patterns of disclosure and consequences of disclosure were discussed in this chapter.

2.1 HIV Disclosure

According to the American heritage dictionary of the English language, disclosure is the act or process of revealing or uncovering something or information. Disclosure is an integral part of HIV infection and as such, the prevention and management of HIV cannot be discussed without mentioning disclosure. Disclosure is also an important component of voluntary counseling and testing (VCT).

The experience has shown that majority of newly diagnosed HIV positive individuals accept the result with shock and fear. To come to term with being HIV positive is a great challenge for both newly diagnosed HIV positive individuals and those already living with the virus (HIV). Depressive thoughts and feelings envelope the individuals and this is often compounded by disclosure thoughts (to tell or not to tell). Many struggle emotionally to strike balance between honesty and protection of their right and privacy. When they eventually conclude to tell, who to tell is another dilemma (Idowu A.F, 2004).

The anxiety over disclosure thoughts (to tell or not to tell) influences the quality of life of individual living with HIV and also the newly diagnosed. They constantly live in anxiety and fear of unknown. Hence, they develop a complex of clinical symptoms ranging from loss of appetite, malaise and weight loss. All these reduce their quality of life on the long run. Generally, anxiety over disclosure influences quality of life but voluntary disclosure has no influence on the quality of life (Prabha S.C et al, 2003).

2.2 Disclosure and legal issues

According to the Centre for Disease Control (CDC), the federal law of the United States of America protects against disclosure under Section 504 of the rehabilitation Act of 1973 and Title II of the American Disability Act of 1990 (ADA). In some states, HIV positive results from the testing sites are sent to the Department of Health. The Department of Health then send the results to the Centre for Disease Control (CDC). In the early stage of the HIV epidemic, some countries had laws in place prohibiting non-disclosure of HIV status to their sexual partners. An example of this was that of a Canadian court verdict that criminalize non-disclosure, the action human right activist saw as a bad precedence establishing stigma and discrimination against people living with HIV (The Body, 2005).

A lot of controversies surround disclosure in the clinical setting and among the members of the society. Some patients are now demanding to know the HIV status of their attending doctor or health worker as a right when an invasive procedure is to be carried out on them. The health workers on the other hand are demanding to know the HIV status of their patients. (The Body, 2006). The current stand and practice in the healthcare circle is the routine testing of pregnant women attending ante-natal clinic after voluntary counseling. No healthcare worker should carry out HIV test on anyone without their consent. But in the case of accidental needle prick by the health worker, HIV tests are occasionally done on patients even when patient refused to give consent. This is to enable the affected health worker to know whether to start post-exposure prophylaxis.

2.3 Disclosure and children

Most children infected with HIV were infected through vertical transmission of HIV (perinatal transmission from mother to child). It is often a great challenge for parents to disclose to these children for fear of guilt and possible devastating effect it may have on the children both socially and emotionally (The Body, 2005).

Disclosure of HIV status is an important part of the process of living with HIV, and is crucial to continuum of HIV care. Disclosure decisions are particularly complex when children are involved because of concern about children's emotional and aptitudinal ability to understand and cope with the nature of the illness, stigma, family relations and concerns about social support. Parents and caregivers are often uncertain how to counsel about disclosure, and opportunities to provide HIV testing and care, and to help families start the discussion about living with HIV are often missed (WHO Guidelines on HIV disclosure, 2012).

2.4 Pattern of disclosure

The nature of disclosure of HIV-serostatus by one partner to the other is the key to arresting the continued growth in the rate of new infections and re-infections among sexual partners. Kalichman and Nachimson (1999) highlighted the importance of disclosure as it is supported as part of the repertoire of "must do" things for anyone/person who has an HIV seropositive status. The authors stated that it supports risk reduction behaviour and helps prevention, care and treatment for people living with HIV and AIDS (PLWHA).

There is myriad of factors affecting each gender's decision not to disclose their status to their partner(s). According to WHO (2002) some of the reasons include loss of economic support, blame, discrimination, disruption of family relationships, emotional and physical abuse. It also further classify the factors as they pertain to women by stating that women are not easily at the liberty to disclose their serostatus due to fear of abandonment, rejection and discrimination, violence and accusation of infidelity. These circumstances lead to the proliferation of HIV infections. Since most men are the bread winners in African households, it may also be clear that they may not disclose their serostatus as well but for a different reason including being economically emancipated, they fear stigma against them or abandonment among other reasons.

Those in a stable relationship disclose better than those with casual sexual partners and the use of condom is positively associated with disclosure to sexual partners (Medley et al, 2004). Studies conducted in United States of America show that 84% of HIV positive mothers have disclosed to their children by ages 12-13 years. Although, disclosure was lower in a similar study done in Belgium among African families than American and European families (Linda et al, 2004).

An understanding of the factors influencing HIV-serostatus disclosure arrangements by men and women is paramount if a solution is to be found to HIV and AIDS prevalence in Botswana. Disclosure is delayed in greater number of people living with HIV (PLWHA). Delayed disclosure accounts for about 70 percent of disclosures (Linda et al, 2006). Many people living with HIV do not consider it necessary to disclose to their former sexual partners. Non-disclosure is 40 percent in past partnerships and 12 percent in current partnerships (Linda et al, 2006). The pattern, to whom and under what circumstances disclosure occurs and the timing of disclosure among men and women are still poorly researched.

2.5 Consequences of disclosure

Full disclosure (before sex) helps sexual partners to make healthy and informed choice about their sex life by practicing safer sex. This enables each partner to have a sense of responsibility to protect each other from contracting or infecting the other. Disclosure does not only reinforce adherence to anti-retroviral drugs but also indirectly prevents new infection and reduces the health care budget on HIV and AIDS (Jane et al, 2004).

Many studies had been conducted on disclosure ranging from studies among pregnant women, gays and the mixed population of men and women (Lauretta et al, 2010; Kebede et al, 2005; Idowu, 2004; Kalichman et al, 1997). Disclosure is a complex phenomenon full of both negative and positive consequences (Medley et al, 2004).

HIV infected individual may choose not to disclose his/her serostatus due to fear of stigma and discrimination (Kassaye et al, 2005). When disclosure occurs, it can be to one and or more of the following persons, the spouse, their sexual partners, family members and/or friends, employer, fellow employees and healthcare workers. In Botswana, 90% of ARV recipients disclose to family, 71% to partner while about 20% never disclose their status for fear of stigma and discrimination (Korte, 2004).

Studies show that the longer the time of living with HIV, the higher the likelihood of disclosure. Research conducted in Rwanda, Tanzania, Kenya, Burkina-Faso, South Africa, Democratic Republic of Congo and Thailand shows that the rate of disclosure ranges from 16.7% to 86% from two weeks to four years (Medley et al, 2004).

Many barriers exist that prevent individuals from disclosing their HIV serostatus. Issiaka et al, (2001), described in his study that fear of being rejected or abandoned and fear of being considered unfaithful account for 71.4% and 24% of non-disclosure respectively. Likewise, Galliard et al, (2000) and Farquhar et al, (2000), attributed 94.1% and 54% to fear of partner's reaction and fear of blame respectively. Some of the barriers to disclosure include fear of rejection and abandonment, fear of being consider unfaithful, fear of domestic violence, fear of blame and fear of physical assault

Disclosure has both positive and negative consequences. According to Medley et al, (2004) the positive consequences include increase in social support and decrease in anxiety, improved access to prevention and treatment programmes, risk reduction and proper future plan and encouragement of behavioural change. The negative consequences include stigma and discrimination, violence following disclosure, depression, shame and feeling of guilt, loss of economic support and risky sexual behavior such as unprotected intercourse.

People may wonder how disclosure of HIV status which prevents risky sexual behavior and help people to make an informed decision on their sexual activity support risky

sexual behavior and unprotected intercourse at the same time. It should be noted in this regard that disclosure has two sides just like a coin. Looking at it from the concordant and disconcordant partners' angle, disclosure can either be positive or negative. For disconcordant partners, study has shown that disclosure brings about informed and safe sexual decisions while concordant partners may throw caution into the wind by engaging in unsafe sexual decisions (Nelson et al, 2002).

Disclosure, seroconcordance, and partner relationship were all interrelated, as well as associated with the likelihood of unprotected intercourse. Unprotected anal intercourse with the most recent partner is more likely when both partners are HIV-positive (Nelson et al, 2002).

Study also shows that people with greater serostatus disclosure to others demonstrated higher rates of adherence, and this relationship between disclosure and adherence was not mediated by practical support for adherence from others (Micheal J et al, 2006).

Studies by Issiaka et al, (2001) showed that 72% of partners were indifferent to the disclosure and 24% have encouraging attitude towards their partners. Another study shows that 62% reported positive reaction from their partners after disclosure while 19% reported more kindness from their partners (Keogh et al, 1994). A study in Zaire recorded no divorce in the twelve month of study after disclosure (Heyward et al, 1993).

Chapter 3: Study Methodology

3.1 Study Setting

The study was conducted in Gaborone city council. Gaborone is the largest city in Botswana with population of 231,592 as recorded in the 2011 census (**www.cso.gov.bw**). It is the commercial nerve centre and the administrative capital city of Botswana. The provision of primary health care of the city (Gaborone) is the sole responsibility of Gaborone District Health Management Team (GDHMT).

Figure 2: Map of Botswana

Source: Google map

The period of the study spanned through November and December 2012. Four Infectious Disease Control Clinics (IDCC) located in Gaborone city council were selected as study sites.

The names of the selected facilities used as the study sites are:

- Bontleng clinic
- Village clinic
- Phase II clinic
- Broadhurst traditional area clinic

3.2 Study Sample

The study sample was taken from a population of patients attending Infectious Disease Control Clinic (IDCC). All patients who have been on antiretroviral therapy for more than 6 months were included in the study.

The sampling method used was quota sampling method. Quota sampling method is a non-probability sampling technique with the aim to end up with a sample where the strata (groups) being studied are proportional to the population being studied. This method was used to select men and women patients attending the Infectious Disease Control Clinics.

After the introduction of the study, the participants who have being on antiretroviral therapy for more than 6 months and are between the age of 20 and 60 years were identified. They were subsequently counseled and the willing individuals were enrolled in the study. The total number of willing participants that took part in the study after counseling was seventy-four (74).

3.3 Study Design

Considering the type and nature of this study where numerical data was used to answer the research question, a quantitative approach using a survey method was used.

3.4 Data Collection Method

The study was conducted using a self-administered questionnaire with structured questions and a few open ended questions given to the participants. The contents of the questionnaire include, knowledge and attitude towards disclosure, timing of disclosure and to whom, reasons for disclosure or non-disclosure, barriers to disclosure and consequences of disclosure. Completed questionnaires were dropped in a sealed box and taken for analysis.

3.5 Ethical Considerations

In compliance with the requirements of human subject research, approval was obtained from the Research Ethics Committees of the University of Stellenbosch, the Health Research Unit at the Botswana Ministry of Health and Gaborone District Health Management Team. The participants were given information sheet that explained the study in details. Consent form was not used due to the sensitive nature of the study because it may be the only link between the information provided, the study and the participant. English and Setswana questionnaires and information sheets were given to the participants depending on the language they are comfortable with.

Pre participation counseling was done by the clinic HIV/AIDS counselor in conjunction with the researcher. The researcher was available to answer questions and concerns while the questionnaires were being completed. Clinical psychologist was also available to deal with any potential psychological risk arising from completing the questionnaire.

3.6 Challenges Encountered

Most targeted potential participants did not participate due to fear of confidentiality. Majority refused to participate despite assurance that there will be no link between them and the data. Men are the most culprits regarding this. As a result of this, the estimated sample size could not be achieved.

Chapter 4: Findings

Data analysis was done using Statistical Package for the Social Sciences (SPSS).

4.1 Demographic Characteristics

Gender, age, marital status, level of education, occupation, income level and household size were the respondents characteristics analyzed.

4.1.1 Gender of Participants

Out of the total number (n= 74) of respondents, 30 were male (40.5%) and 44 were females (59.5%).

4.1.2 Age of Participants

From the total number (n= 74) of respondents, five were aged 20-30 (6.8%), 15 were of the age group 31-35 (20.3%),28 were aged 36-40 (37.8%), 12 were of age 41-45 (16.2%), six were aged 46-50 (8.1%), seven were in the age group 51-55 (9.5%) and only one respondents in the age group 56-60 (1.4%). (Table 1)

Age(Years)	Frequency	Percentage
Below 26-30	5	6.8
31-35	15	20.3
36-40	28	37.8
41-45	12	16.2
46-50	6	8.1
51-55	7	9.5
56-60	1	1.4

Table 1: Frequency distribution by age (n=74)

4.1.3 Educational level

Out of the total number (n=74) of respondents, three had no formal education (4.1%), one attended adult literacy class (1.4%), one attended primary school but never finish (1.4%), six had standard seven certificate (8.1%), 12 attended secondary school but never finish (16.1%), 37 had secondary school certificate (50.0%) and 14 (18.9%) had post-secondary education (Table 2).

Education	Frequency	Percentage
No formal or non-formal education	3	4.1
Attended adult literacy class	1	1.4
Attended primary school but never finished	1	1.4
Had standard seven certificate	6	8.1
Attended secondary school but never finished	12	16.2
Had secondary school certificate	37	50
Post-secondary education	14	18.9

Table 2: Frequency distribution by education (n=74)

4.1.4 Marital status

From the total number (n=74) respondents, 26 were single living with sexual partner (35.1%), 32 were single not living with sexual partner (43.2%), six were single with no sexual partner (8.1%), eight were married living with spouse (10.4%), one was divorced living with sexual partner (1.4%) and one (1.4) was a widow (Table 3).

Marital Status	Frequency	Percentage
Single living with sexual partner	26	35.1
Single not living with sexual partner	32	43.2
Single with no sexual partner	6	8.1
Married living with spouse	8	10.8
Divorced living with sexual partner	1	1.4
Widow	1	1.4

Table 3: Frequency distribution by marital status (n=74)

4.1.5 Occupation

From the total number (n=65) respondents, 12 were traders (16.2%), 15 were civil servants (20.3%), seven were involved in artisan work (9.5%), nine were farmers (12.2%), one (1.4%) participant each for counselor, caterer, auditor, hairdressing and musician. Two were security officers (2.7%), three work in private sector (4.1%) and 12 (16.2%) were unemployed (Table 4).

Occupation	Frequency	Percentage
Trading	12	16.2
Civil servant	15	20.3
Artisan work	7	9.5
Farming	9	12.2
Counselling	1	1.4
Catering	1	1.4
Security Officer	2	2.7
Auditor	1	1.4
Private sector	3	4.1
Hairdressing	1	1.4
Musician	1	1.4
Unemployed	12	16.2

Table 4: Frequency distribution by occupation (n=65)

4.1.6 Income

Out of the total number (n=72), 26 earned below 2500 Pula (35.1%), 17 earned 2501-5000 Pula (23%), nine earned 5001-7500 Pula (12.2%), six earned 7501-10000 Pula (8.1%), two earned 10001-12500 Pula (2.7%), 12 had no source of income (16.2%) and none of the respondents earned above 12501 Pula (Table 5). Table 5: Frequency distribution by income

Income (In Botswana Pula)	Frequency	Percentage
Below 2500	26	35.1
2501-5000	17	23.0
5001-7500	9	12.2
7501-10000	6	8.1
Above 10000	2	2.7
No income	12	16.2

4.1.7 Household size

Out of the total number (n=72) respondents, three were living alone (4.1%), 29 had household size of 2-3 people (39.2%), 20 had household size of 4-5 people (27%), 15 had household size of 6-7 people (20.3%), two had household size of 8-9 people (2.7%) and three (4.1%) had more than 9 household size (Table 6).

Number of people living in Household	Frequency	Percentage
I am the only person	3	4.1
2-3 people	29	39.2
4-5 people	20	27.0
6-7 people	15	20.3
8-9 people	2	2.7
Above 9	3	4.1

Table 6: Frequency distribution by household size

4.2 Frequency of contact with health workers for counselling

4.2.1 Men

Out of the 28 respondents, 20(71.4%) had received counselling between one to three times while eight (28.5%) received counselling more than three times.

4.2.2 Women

Out of the 40 respondents, 35(87.5%) had received counselling between one to three times while five (12.5%) received counselling more than three times (Figure 3).

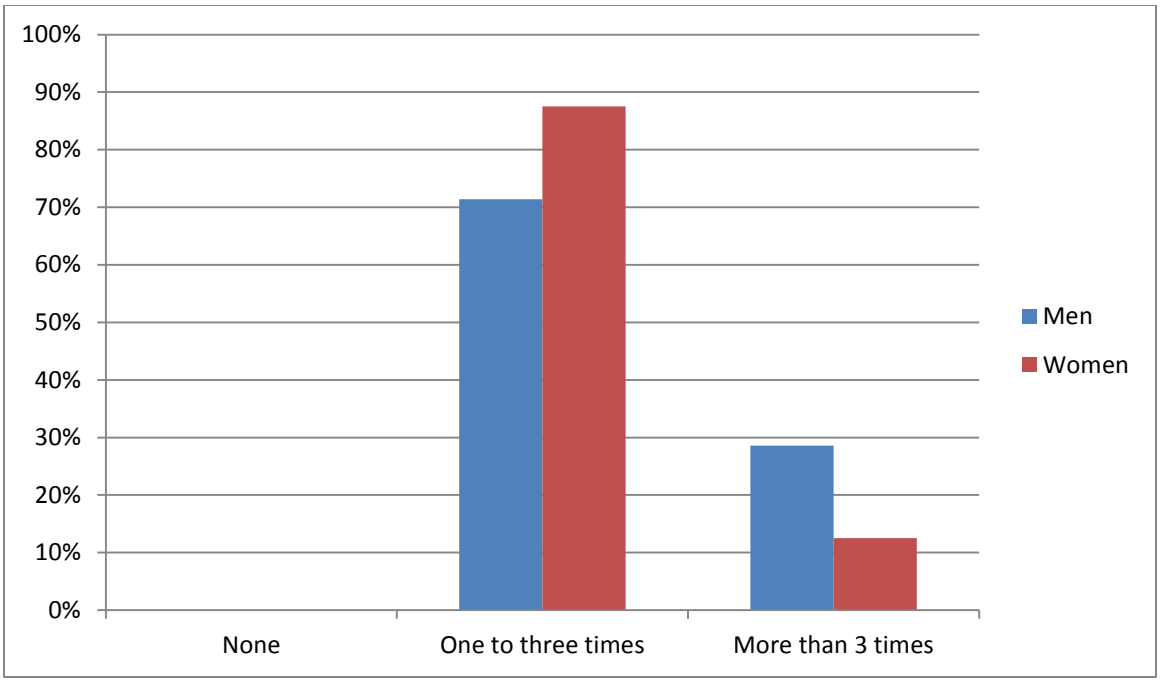


Figure 3: Frequency of contact with health workers for counselling

4.3 Medium through HIV was contracted

4.3.1 Men

Out of the 30 male respondents, 15(50%) were infected through sexual intercourse, Nine (30%) were also infected through the use of unsterilized sharp objects and six (20%) did not know how they got infected. None of the male respondents was infected through vertical transmission (from birth).

4.3.2 Women

Out of the 44 female respondents, 26(59.1%) got infected through sexual intercourse, 10(22.7%) also got infected through the use of unsterilized sharp objects, one (2.2%) got infected through vertical transmission (from birth) and seven (15.9%) did not know how they got infected.

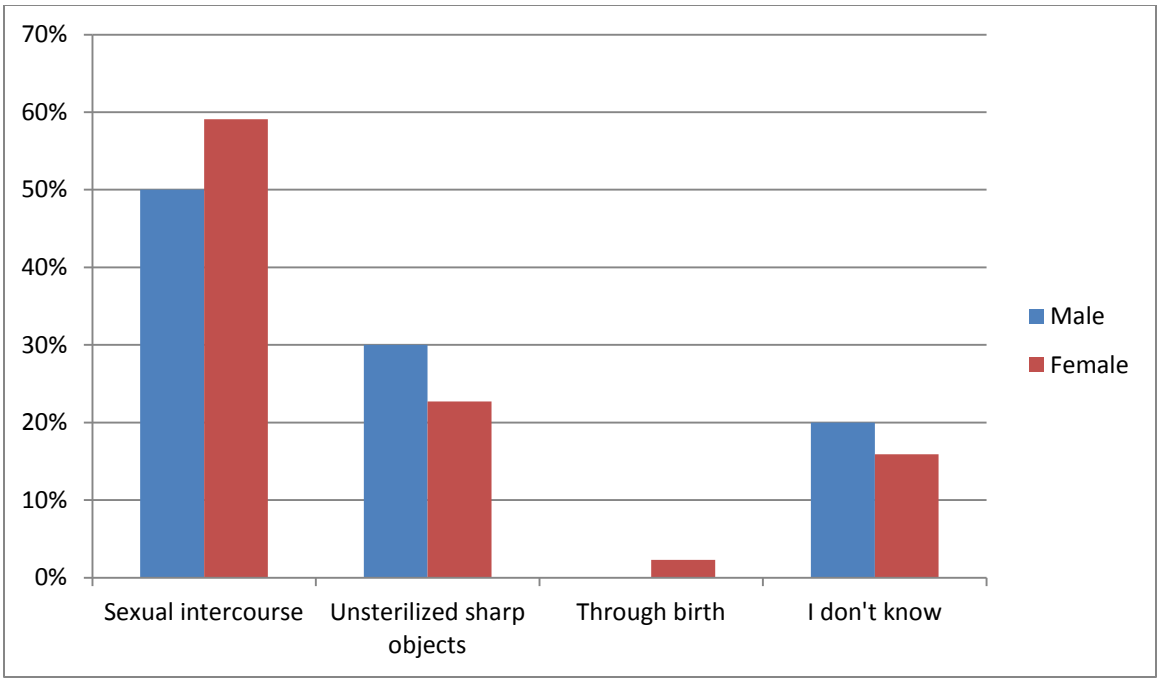
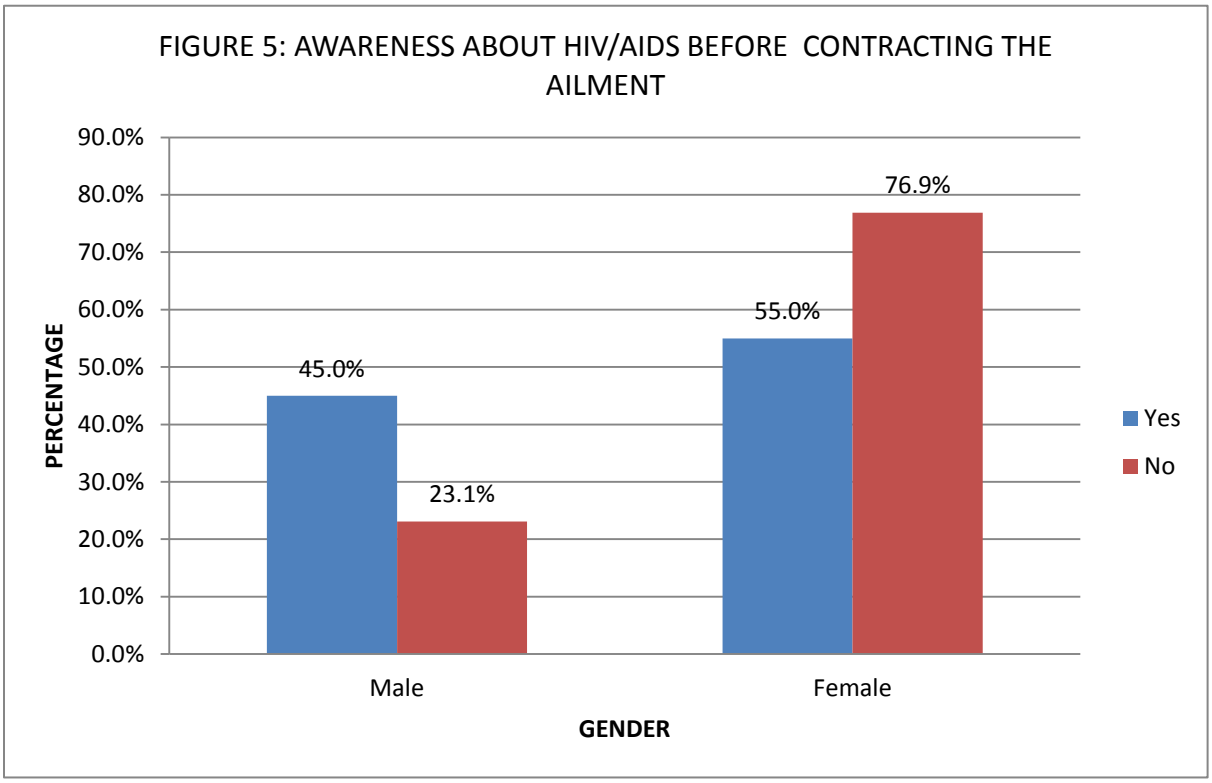


Figure 4: Medium through which HIV was contracted

4.4 Awareness about HIV before contracting the disease

Forty-five percent of men who responded to this question were aware of the disease while 23.1% of men had no awareness about the disease before getting infected.

On the other hand, 55% of women who responded to the question had full awareness of the disease while 76.9% had no awareness before getting infected.



4.5 Why did you not prevent the infection?

4.5.1 Men

Out of the 13 respondents, six (46%) believed it could not happen to them, four (30%) could not restrain themselves, two (15%) tried condom while one (7.6%) did not know that their partners were HIV positive.

4.5.2 Women

Out of the 24 respondents, five (20%) believed it could not happen to them, three (12.5%) could not restrain themselves, two (8.3%) tried condom while 14 (58.3%) did not know that their partners were HIV positive (Figure 6).

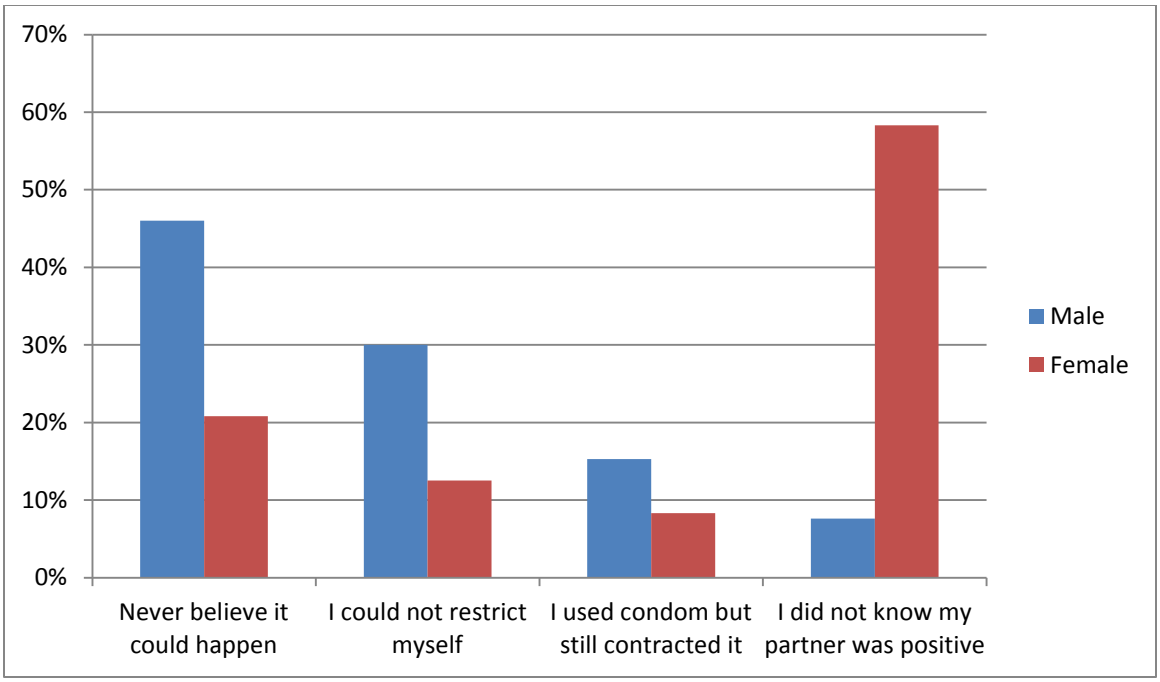


Figure 6: Why did you not prevent the infection

4.6 Information disclosure on HIV status

The data below show the disclosure by gender of respondents in relation to age, education level, marital status, occupation, income and household size.

4.6.1 Age

4.6.1.1 Men

Only one respondent in the age group of below 30 years (4.34%) disclosed his HIV status and 0ne (4.34%) respondent did not disclose, 12(52.1%)between 30-50 years disclosed while four (17.3%) did not disclose, four (17.3%) disclosed in 50 years and above category while one (4.34%) did not disclose.

4.6.1.2 Women

Out of the 36 respondents, two (5.5%) respondents in the age group of below 30 years disclosed their HIV status and no respondent did not disclose, 29(80.5%) between 30-50 years disclosed while two (5.5%) did not disclose, two (5.5%) disclosed in 50 years and above category while one (2.8%) did not disclose (see the figure below).

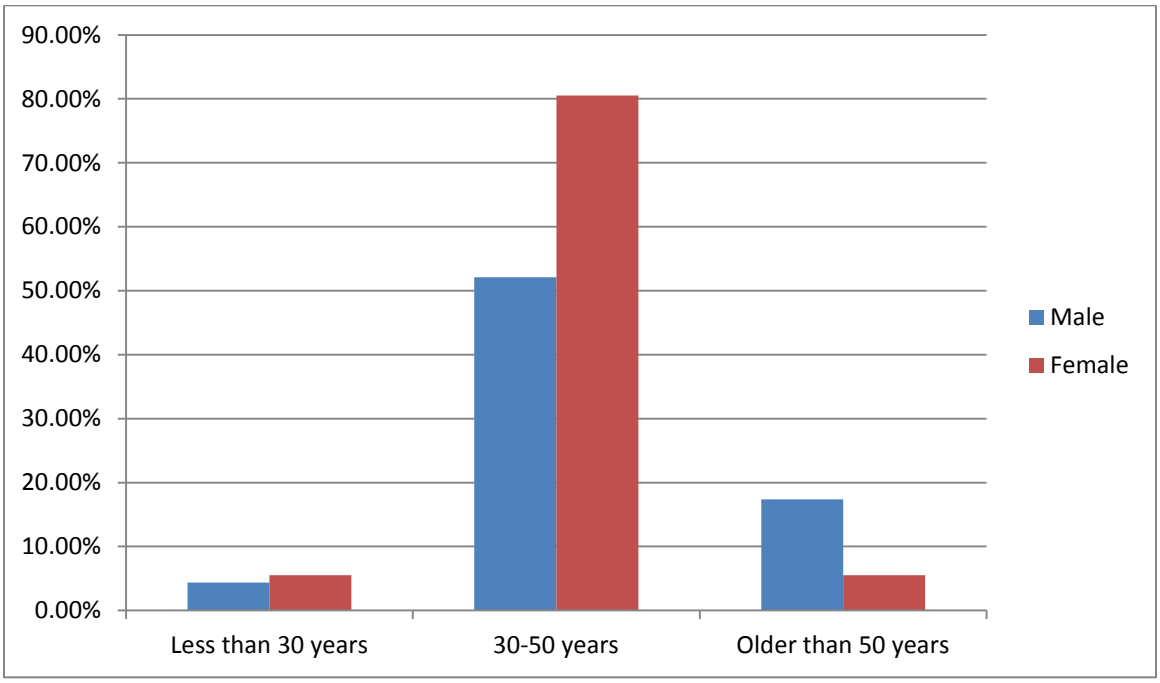


Figure 7: Disclosure in relation to age

4.6.2 Education

4.6.2.1 Men

Out of the 26 respondents, only one (3.84%) in the category without education disclosed his status. Also, only one (3.84%) respondent disclosed his status in the category of those with primary education. Disclosure was highest among those with secondary education and above with 20(77%) respondents while four (15.3%) did not disclose in this category.

4.6.2.2 Women

Out of the 40 respondents, one (5%) in the category without education disclosed their status. Seven (17.5%) respondents disclosed their status in the category of those with primary education. Disclosure was highest among those with secondary education and above with 25(62.5%) respondents while nine (15%) did not disclose in this category (figure 8).

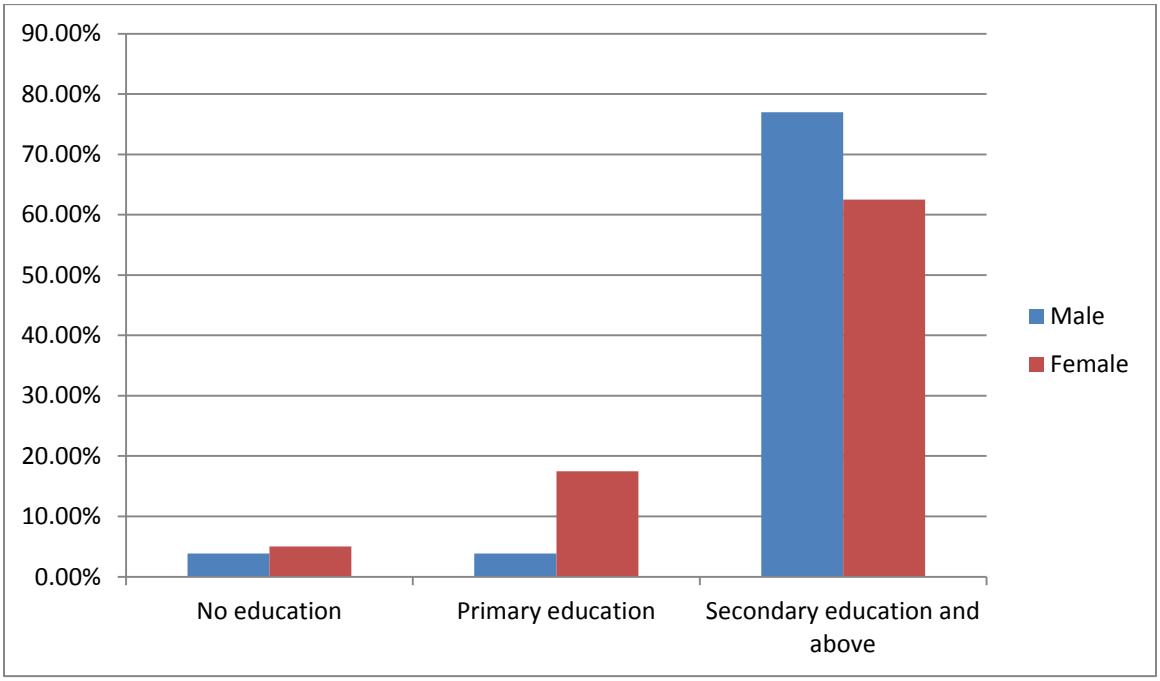


Figure 8: Disclosure in relation to level of education

4.6.3 Income

4.6.3.1 Men

Out of the 29 respondents, eight (27.6%) with monthly income of less than 2500 Pula disclosed their status while two did not disclose (6.8%), three (10.3%) with income

between 2500-5000 disclosed while two (6.8%) did not disclose. Those earning above 5000 had 34.4% disclosure with 10 respondents while four (13.8%) did not disclose in this category.

4.6.3.2 Women

Out of the 43 respondents, 16(37.2%) with monthly income of less than 2500 Pula disclosed their status. Nine (21%) with income between 2500-5000 disclosed while three (6.97%) did not disclose. Those earning above 5000 had 34.8% disclosure with 15 respondents (Figure 9)

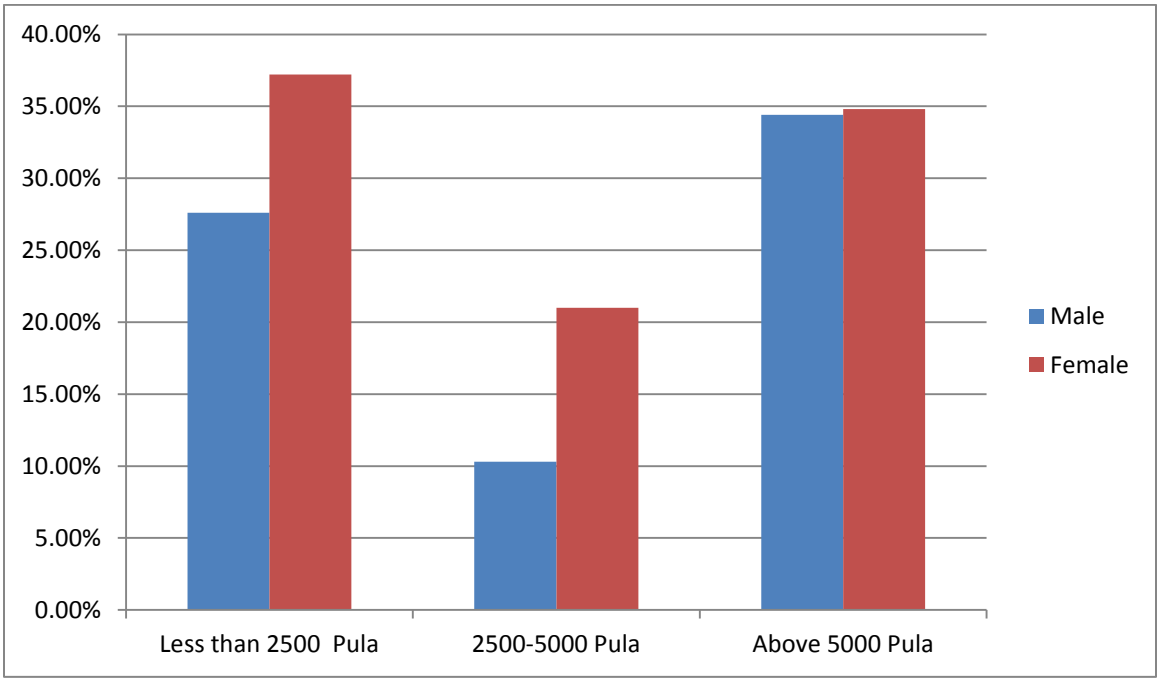


Figure 9: Disclosure in relation to income

4.6.4 Marital status

4.6.4.1 Men

Out of the 30 male respondents, 20(66.6%) singles disclosed their status and four (13.3%) did not. Four (13.3%) married/co-habiting respondents disclosed their status while two (6.66%) did not disclose.

4.6.4.2 Women

Out of the 34 female respondents, 26(76.4%) singles disclosed their status and two (5.88%) did not. Five (14.7%) married/co-habiting respondents disclosed their status while only one (2.9%) respondent disclosed in the category 'others'

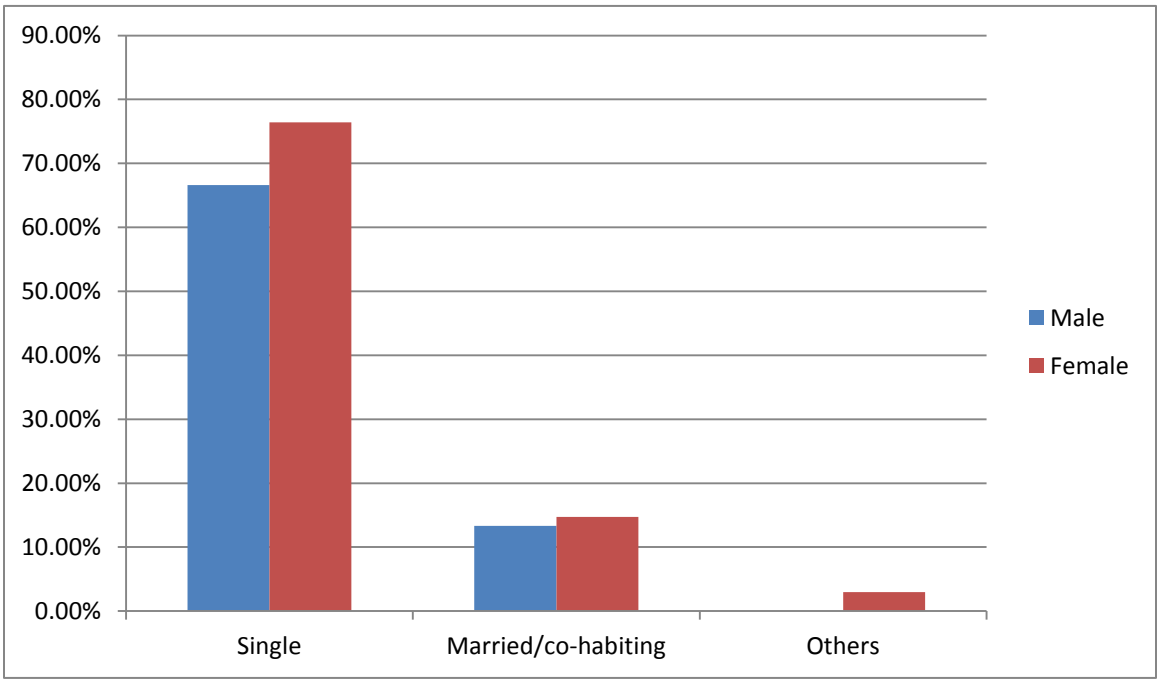


Figure 10: Disclosure in relation to marital status

4.6.5 Employment

4.6.5.1 Men

Out of the 26 men that responded, 19(73%) who were employed disclosed their status while seven (27%) did not disclose. No respondent was recorded in the unemployed category.

4.6.5.2 Women

Out of the 38 respondents, 27(71%) who were employed disclosed their status while two (5.26%) did not disclose. Nine (23.7%) unemployed respondents disclosed their status while there was no respondent for non-disclosure.

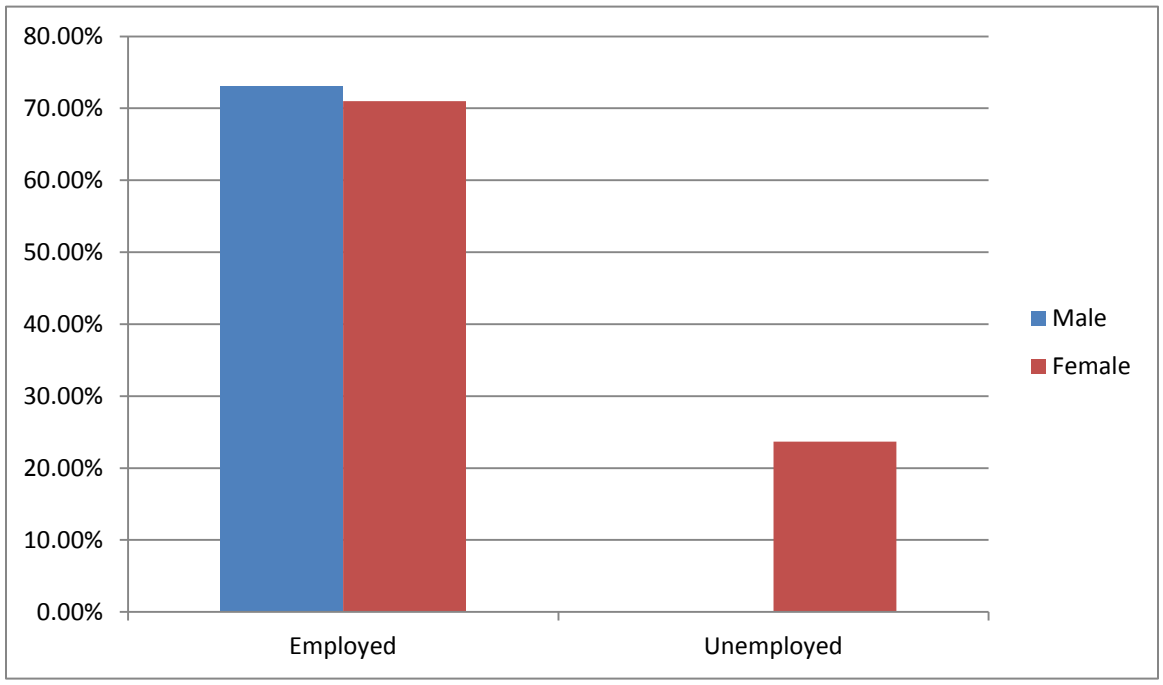


Figure 11: Disclosure in relation to employment

4.6.6 Household size

4.6.6.1 Men

A total of 28 men responded in this category. Nine (32.1%) in each of the household size of 1-3 and 4-5 people disclosed their status while three (10.7%) and one (3.57%) did not disclose in each household size respectively. Three (10.7%) disclosed in household size of more than 5 people and four (14.28%) did not disclose

4.6.6.2 Women

A total of 42 women responded in this category. 19(45.2%) in the household size of 1-3 people disclosed their status and one (2.38%) did not disclose. Nine (21.4%) disclosed in household size of 4-5 people while one (2.38%) did not. 12(28.57%) disclosed in household size of more than five people (figure 12).

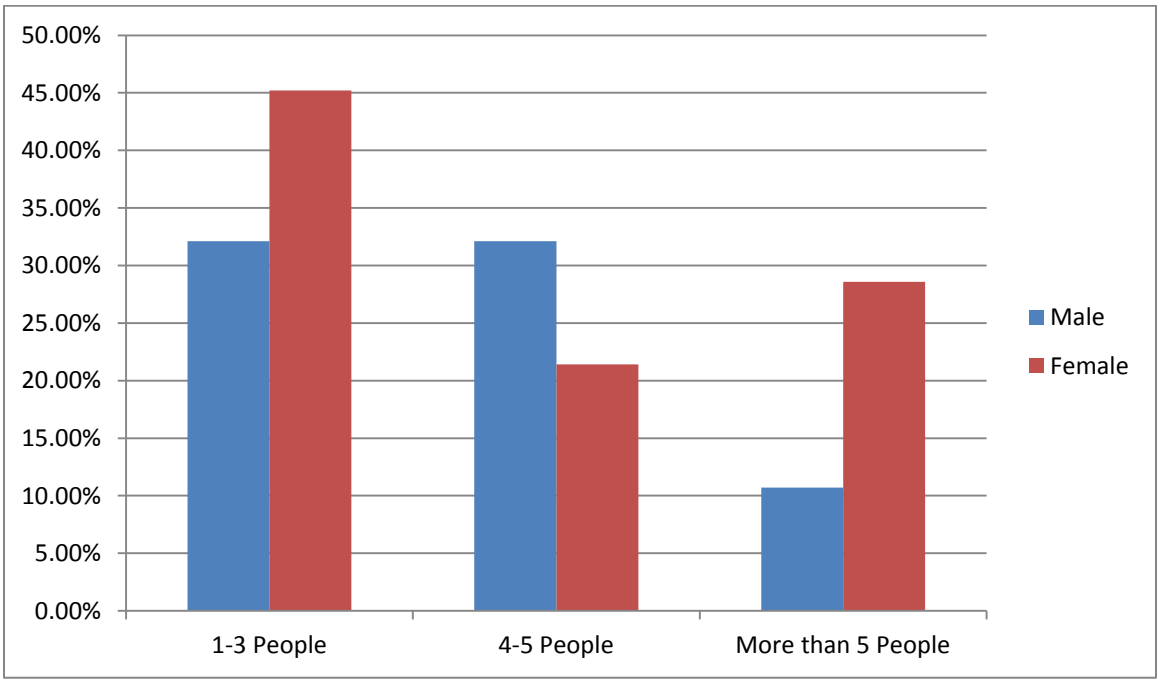


Figure 12: Disclosure in relation to household size

4.7 Have you disclosed your HIV status?

Twenty-two (73%) men disclosed their HIV status while 42(95%) women disclosed their status.

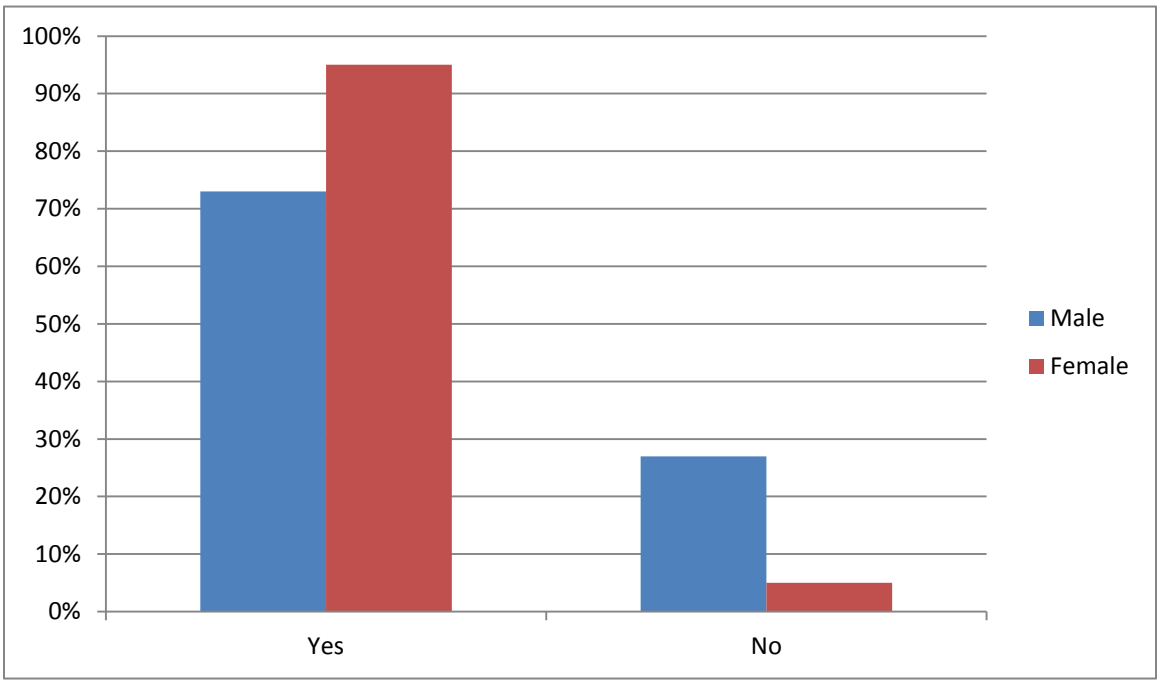


Figure 13: Have you disclosed your HIV status?

4.8 Who did the respondents disclose to?

4.8.1 Men

Out of the 22 respondents in this category, three (14%) disclosed to their spouse, nine (41%) disclosed to casual sexual partner(s), two (9%) disclosed to friend while eight (36%) disclosed to relatives.

4.8.2 Women

Out of the 42 respondents in this category, nine (21%) disclosed to their spouse, 14(33%) disclosed to casual sexual partner(s), two (5%) disclosed to friend while 17(41%) disclosed to relatives. (Figure 14)

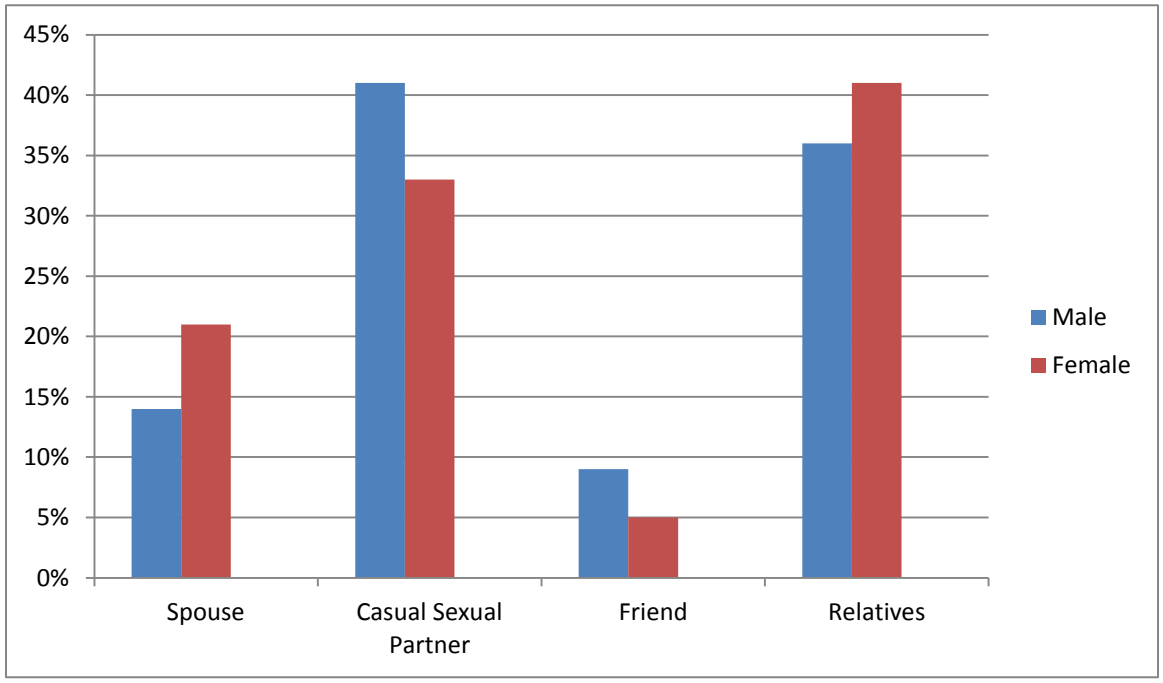


Figure 14: To whom HIV status was disclosed

4.9 Disclosure determinants

A Likert scale was used to access the determinants of disclosure. The respondents were asked to answer this section irrespective of whether they have disclosed their HIV status or not.

4.9.1 I see no need to divulge information on my HIV status

4.9.1.1 Men

Out of the 29 male respondents, nine (31%) agreed, 15(52%) disagreed while five (17%) were undecided.

4.9.1.2 Women

Out of the 44 female respondents, 17(39%) agreed, 25(56%) disagreed while two (5%) were undecided (figure 15).

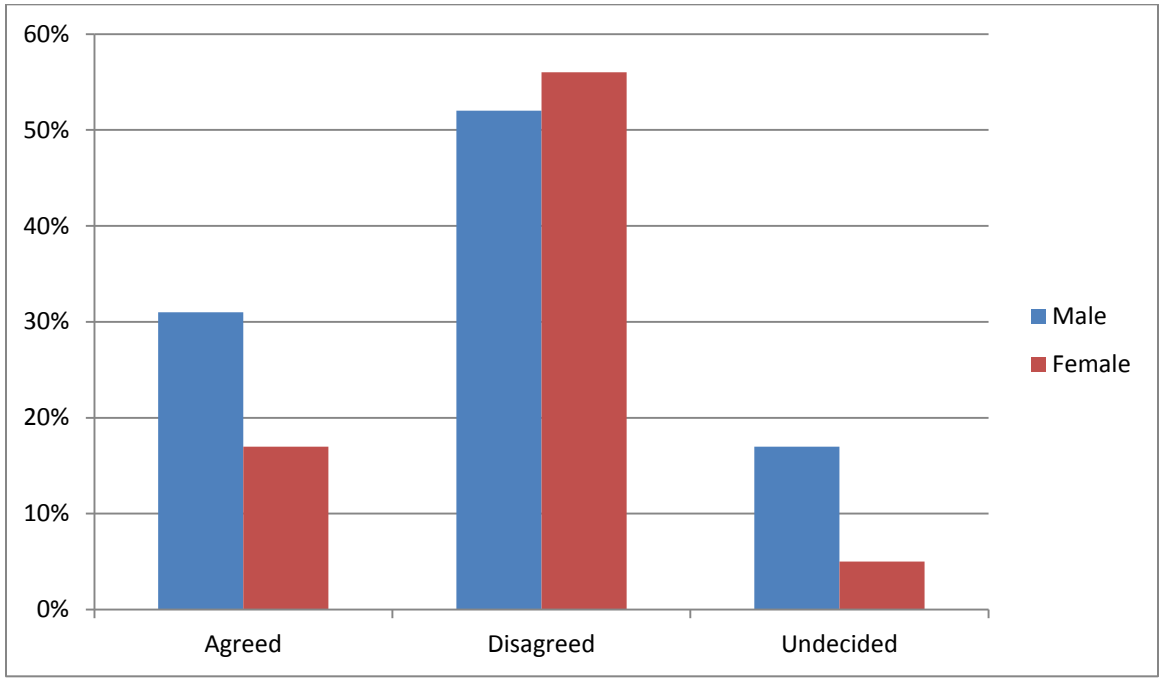


Figure 15: I see no need to divulge information on my HIV status

4.9.2 I do not like to be treated as an outcast by the society. As such I did not disclose the information on my HIV status

4.9.2.1 Men

A total of 30 men responded in this category. 18(60%) agreed, eight (27%) disagreed while four (13%) were undecided.

4.9.2.2 Women

A total of 44 women responded. 17(39%) agreed, 23(52%) disagreed while four (9%) were undecided. (Figure 16)

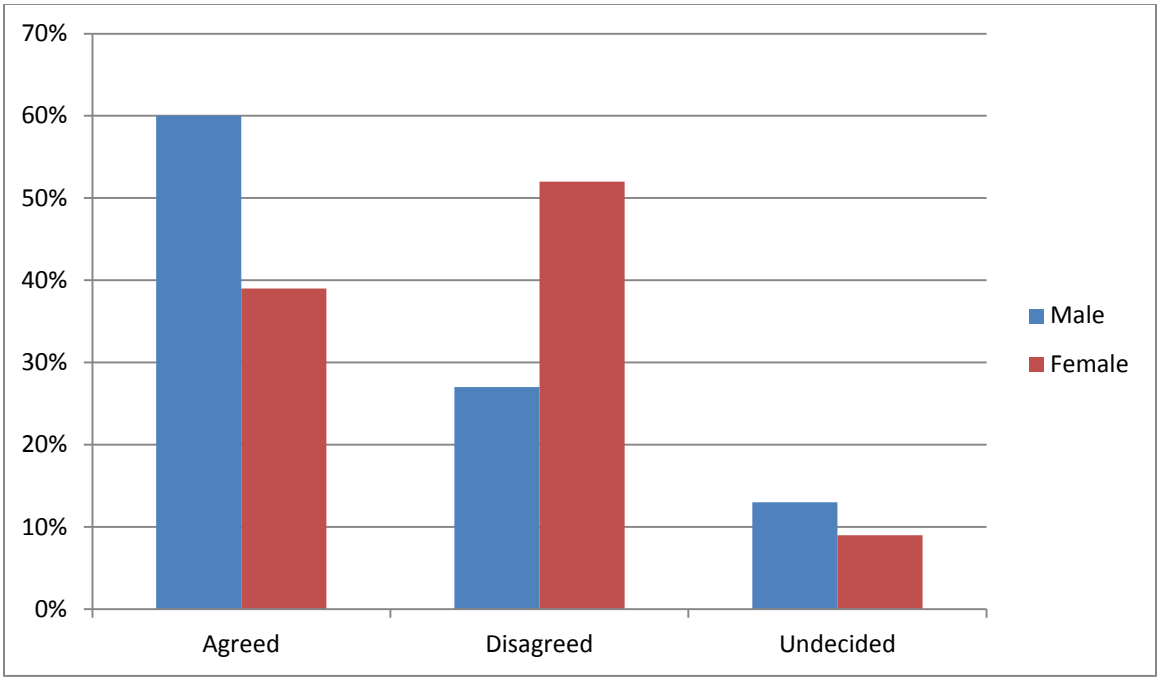


Figure 16: I do not like to be treated as an outcast by the society. As such I did not disclose

4.9.3 I am afraid of what people would think about me if I disclose information on my HIV status

4.9.3.1 Men

Thirty men responded in this category. 16(53%) agreed, eight (27%) disagreed while six (20%) were undecided.

4.9.3.2 Women

Forty-four women responded in this category. 13(30%) agreed, 24(56%) disagreed while six (14%) were undecided (figure 17).

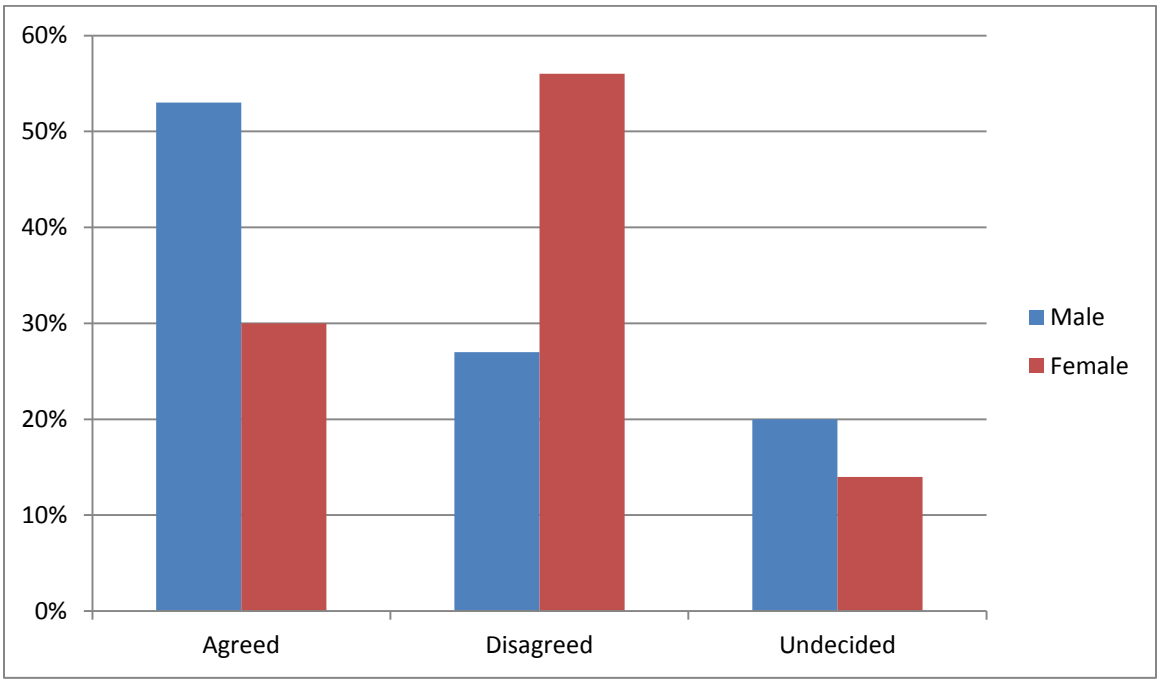


Figure 17: I am afraid of what people would think about me if I disclose information on my HIV status

4.9.4 I disclosed information on my status as soon as I realised I got infected with HIV

4.9.4.1 Men

Out of the 29 male respondents, 12(42%) agreed, 14(48%) disagreed while three (10%) were undecided.

4.9.4.2 Women

Out of the 43 female respondents, 29(68%) agreed, 10(23%) disagreed while four (9%) were undecided (figure 18).

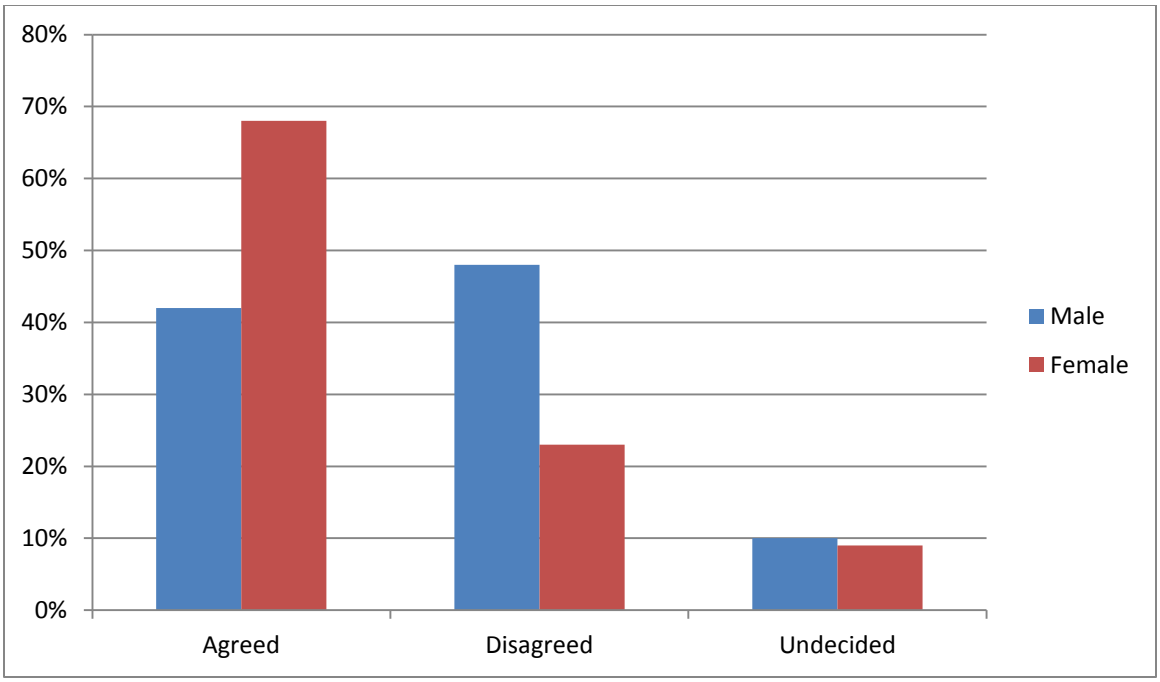


Figure 18: I disclosed information on my status as soon as I realised I got infected with HIV

4.9.5 There is no reason why information should not be disclosed because I see HIV infection and its associated symptoms just as any other disease(s)

4.9.5.1 Men

Out of the 30 male respondents, 10(33%) agreed, 19(64%) disagreed. Only one (3%) was undecided on the question.

4.9.5.2 Women

Out of the 42 female respondents, 20(48%) agreed, 19(45%) disagreed while three (7%) were undecided (figure 19).

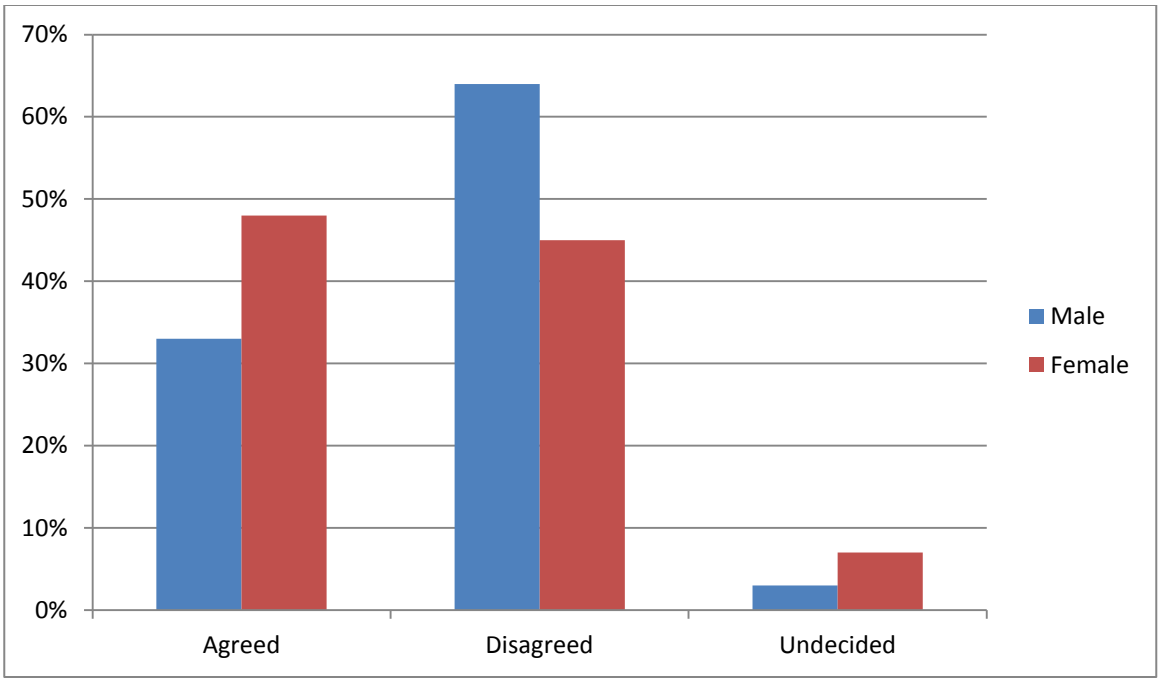


Figure 19: There is no reason why information should not be disclosed because I see HIV infection and its associated symptoms just as any other disease(s)

4.9.6 I disclosed the information about my status to prevent me from spreading the ailment

4.9.6.1 Men

There are 25 respondents in this category. 13(52%) agreed, 12(48%) disagreed while there was no response for undecided.

4.9.6.2 Women

There are 40 respondents in this category. 32(80%) agreed, seven (18%) disagreed while one (2%) was undecided (Figure 20).

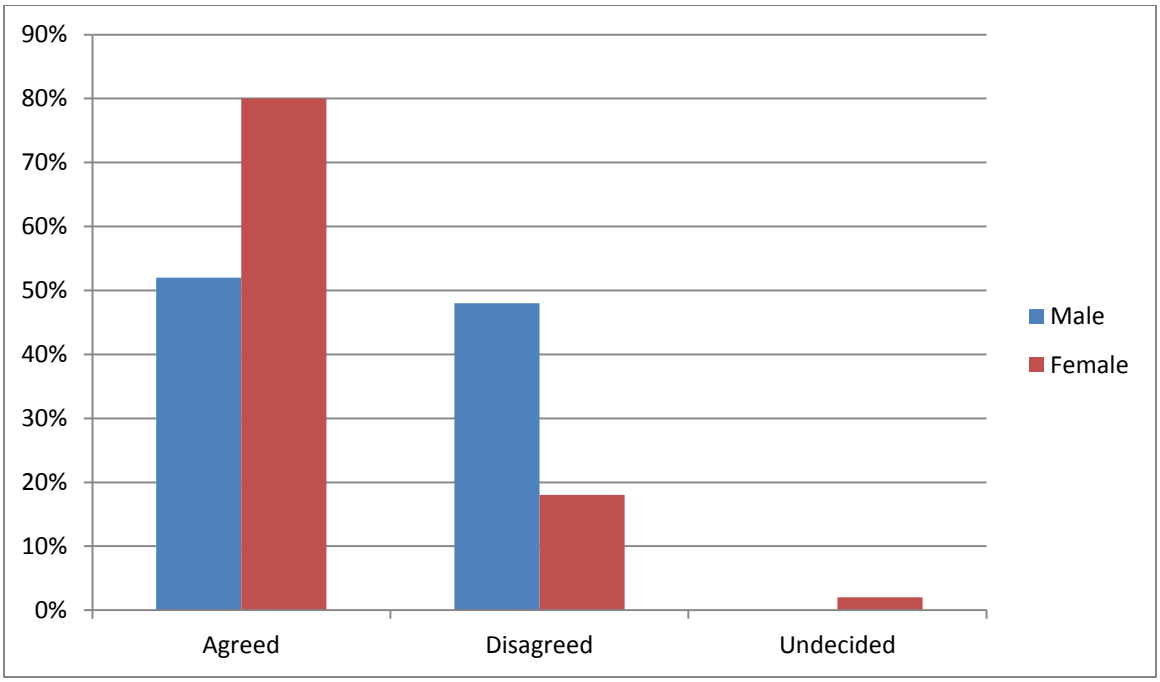


Figure 20: I disclosed the information about my status to prevent me from spreading the ailment

4.9.7 Not disclosing the information on my HIV status would amount to carrying heavy burden all alone

4.9.7.1 Men

Twenty-seven men answered this question. 11(41%) agreed, 11(41%) also disagree while five (18%) were undecided.

4.9.7.2 Women

Forty-four women answered this question. 25(57%) agreed, 13(30%) disagreed while six (13%) were undecided (figure 21).

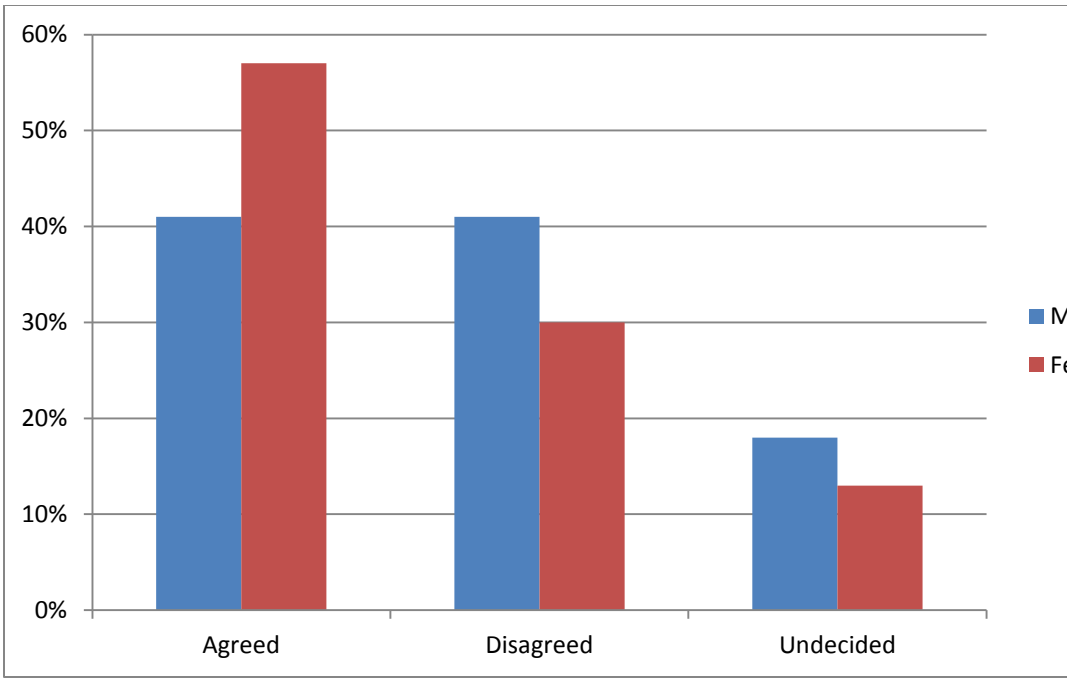


Figure 21: Not disclosing the information on my HIV status would amount to carrying heavy burden all alone

4.9.8 I disclose the information on my HIV status so that I could receive help and quality advice from health workers/experts

4.9.8.1 Men

Out of the 28 male respondents, 13(46%) agreed, 12(43%) disagreed while three (11%) were undecided

4.9.8.2 Women

Out of the 43 female respondents, 35(81%) agreed, eight (19%) disagreed while (0%) were undecided (Figure 22)

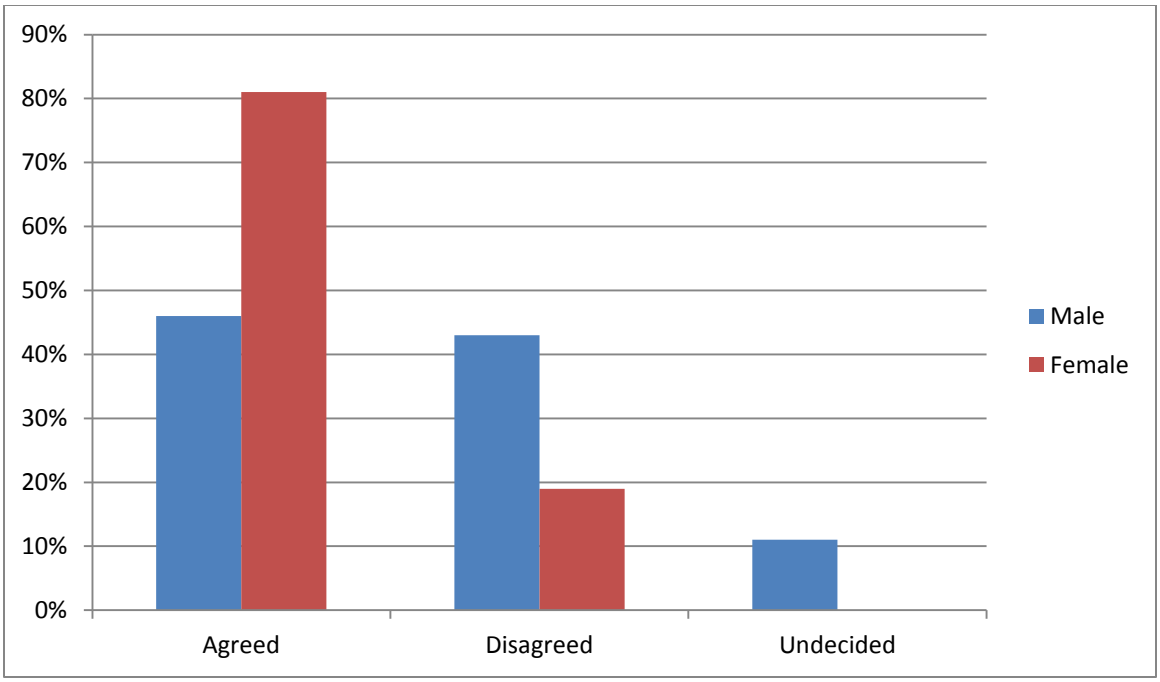


Figure 22: I disclose the information on my HIV status so that I could receive help and quality advice from health workers/experts

4.9.9 I disclosed information on my HIV because I want my experience to teach uninfected individuals a lesson

4.9.9.1 Men

In this category of 29 men, 15(52%) agreed, 11(38%) disagreed while three (10%) were undecided.

4.9.9.2 Women

In this category of 43 women, 28(65%) agreed, 11(26%) disagreed while four (9%) were undecided (Figure 23).

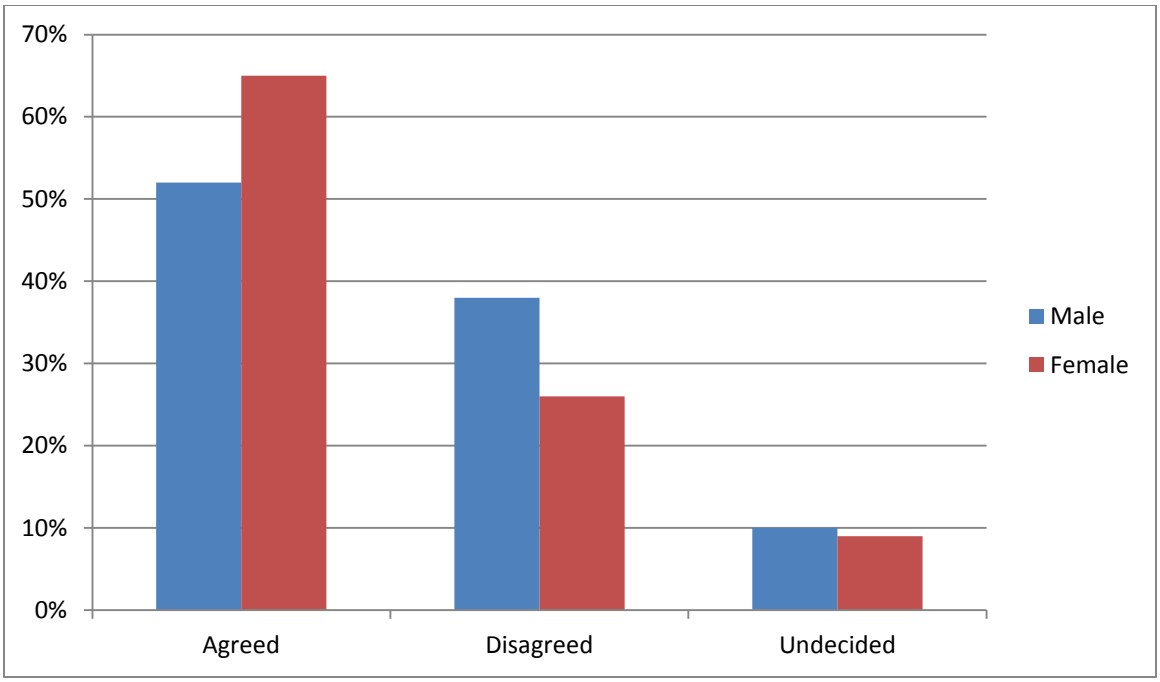


Figure 23: I disclosed information on my HIV because I want my experience to teach uninfected individuals a lesson

4.9.10 I disclosed my HIV status because I could not hide my medications from my partner/friends/relatives

4.9.10.1 Men

Out of the total number of 29 men, 11(38%) agreed, 16(55%) disagreed while two (7%) were undecided.

4.9.10.2 Women

Out of the total number of 43 women, 21(49%) agreed, 21(49%) also disagreed while one (2%) was undecided (figure 24).

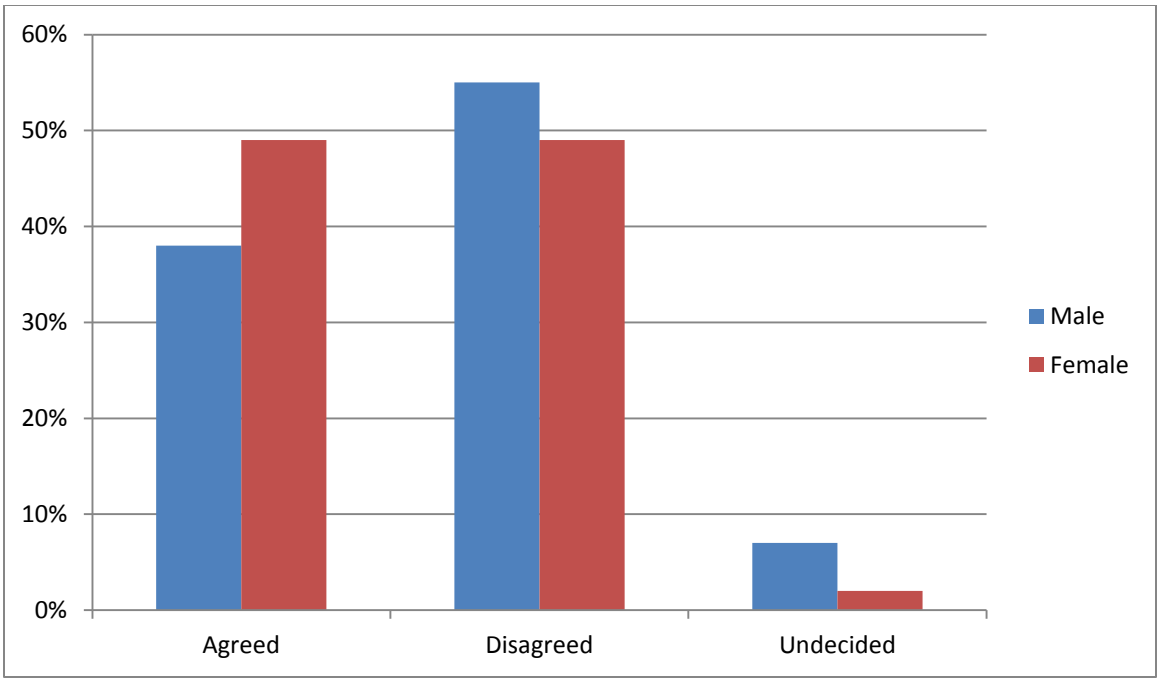


Figure 24: I disclosed my HIV status because I could not hide my medications from my partner/friends/relatives

4.9.11 I disclosed my HIV status when I was seriously ill

4.9.11.1 Men

The total number of men in this category were 27, seven (26%) agreed and 20(74%) disagreed.

4.9.11.2 Women

The total number of women in this category were 40, six (15%) agreed, 31(78%) disagreed while three (7%) were undecided (Figure 25).

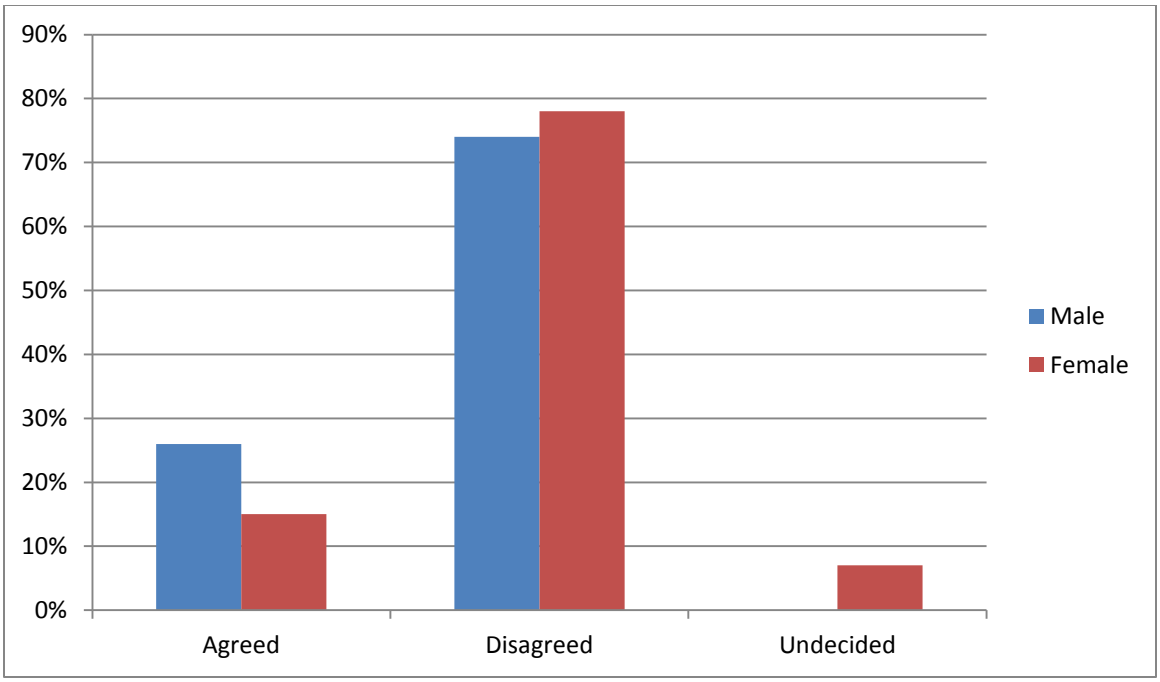


Figure 25: I disclosed my HIV status when I was seriously ill

4.9.12 I disclosed my HIV status because my friends disclosed their status

4.9.12.1 Men

Thirty men responded in this category. Seven (23%) agreed, 21(70%) disagreed while two (7%) were undecided.

4.9.12.2 Women

Forty women responded to this question. Seven (16%) agreed, 34(79%) disagreed while two (5%) were undecided (Figure 26).

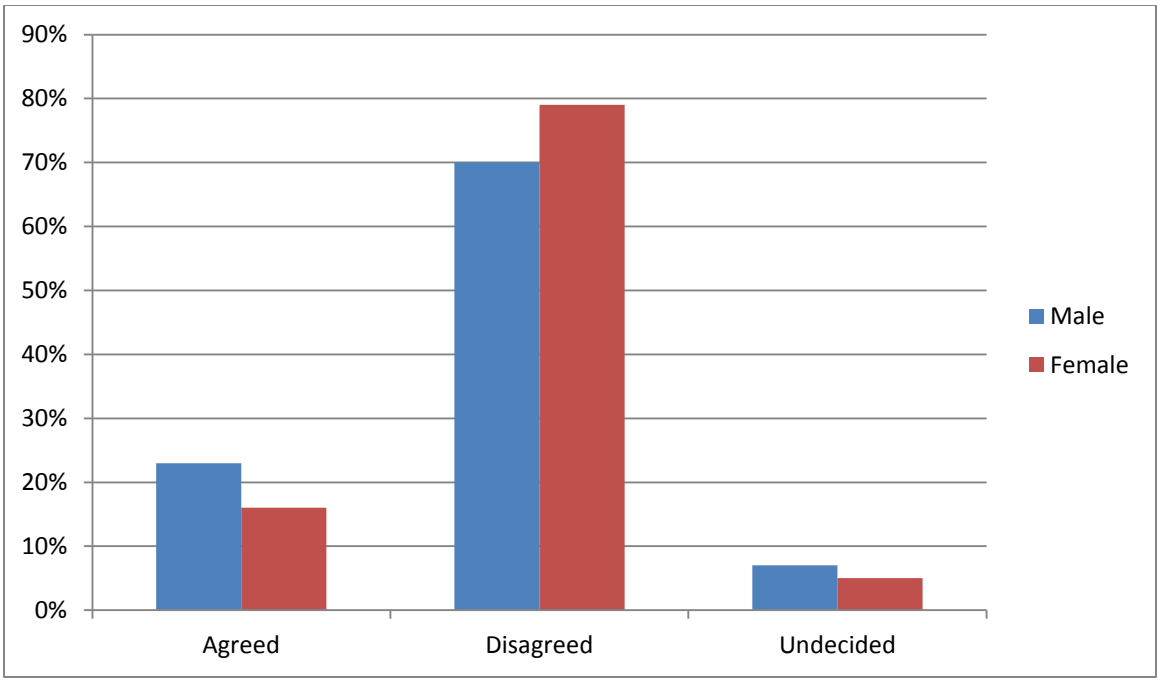


Figure 26: I disclosed my HIV status because my friends disclosed their status

4.9.13 I disclosed my HIV status because people are suspicious of my frequent hospital/clinic visits

4.9.13.1 Men

Out of the 30 men in this category, 10(33%) agreed, 18(60%) disagreed while two (7%) were undecided.

4.9.13.2 Women

Out of the 42 women in this category, eight (19%) agreed, 30(71%) disagreed while four (10%) were undecided (figure 27).

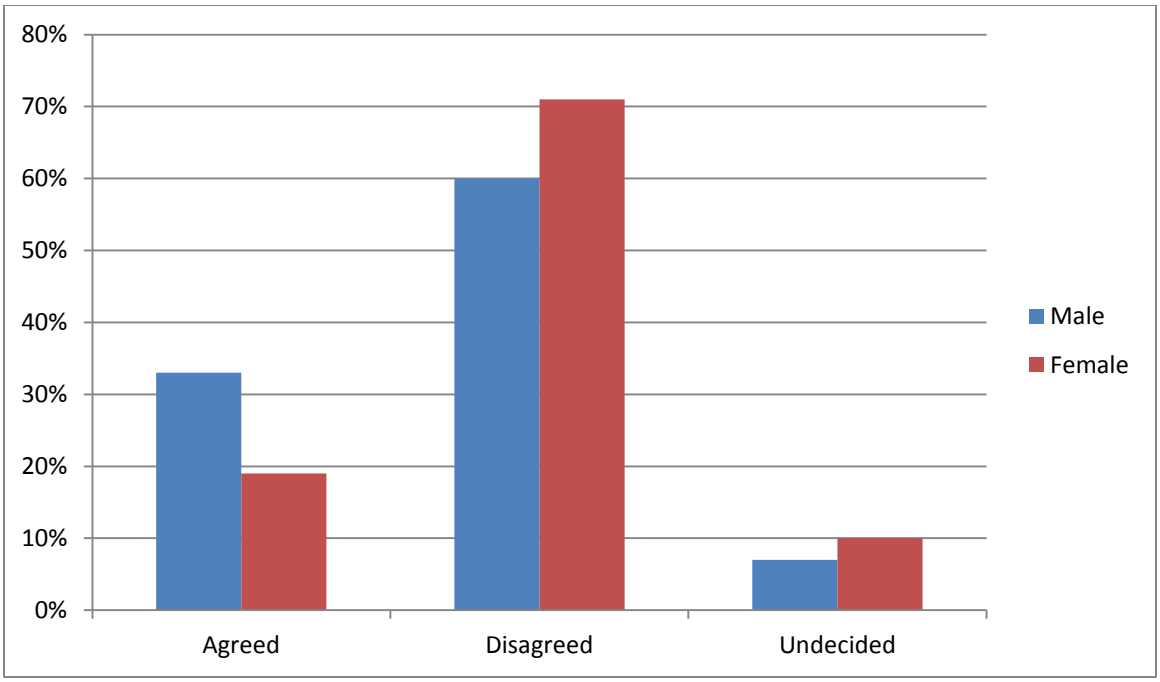


Figure 27: I disclosed my HIV status because people are suspicious of my frequent hospital/clinic visits

Chapter 5: Discussion

This chapter contains the findings of the study.

5.1 Demographic Characteristics

The study shows that majority of respondents were females, (59.5%). This corresponds to the UNAIDS global report of 2011 which stated that 130,000 men and 170,000 women were living with HIV in Botswana. Regarding age, (37.8%) of respondents were aged 36-40 years, followed by (20.8%) those aged 31-35 and (16.2%) for those 41-45 years. The remaining ages were less than ten percent. This result shows that most of respondents were in their productive years and this supports the findings by Korte (Korte, 2004).

The study revealed that half (50%) of respondents had secondary certificate and (18.9%) had post-secondary education. This could mean that the majority did not attend post-secondary education as they tend not to further their studies after secondary education. Forty-three percent of respondents were not living with sexual partners, (35.1%) were living with sexual partner and 10% were married and living with spouse. This could mean that the majorities were not married and the findings support the Botswana Demographic Survey, 2006 which stated that 64.2% of women were never married.

The majority of respondents were low income earners (below P2500), followed by (23.0%) for those earning between P2500 – P5000.00 and (16.2%) for those with no earnings. This may not mean that majority of people living with HIV are low income earners because the study sites are the free IDCC centers attended mainly by people of low social economic class. The high income earners on the other hand attend private health institutions which were not included in this study.

5.2 Medium through HIV was contracted

The study showed that 50% of men and 59.1% of women got infected through sexual intercourse, 30% of men and 22.7% of women were also infected through the use of unsterilized sharp objects while 20% of men and 15.9% of women did not know how they got infected. None of the male respondents was infected through vertical transmission (from birth) but vertical transmission was recorded in females (2.2%) The findings are similar to the study by Medley (Medley et al, 2000) which revealed that sexual intercourse was the most common mode of transmission.

An interesting discovery is the finding of female respondents who were infected through vertical transmission. This could be due to the fact that the children who got infected from birth are now growing into adulthood because of the use of antiretroviral therapy.

5.3 Awareness about HIV before contracting the disease

The study showed that the level of awareness was higher in women than men. 55% and 45% of women and men respectively were fully aware of the disease before they were infected. The higher level of awareness in women may be due to the fact they visit health clinics more than men especially antenatal attendance. Despite the level of awareness in both men and women, forty-six percent of men and 20% of women believed that they cannot contract the infection. Majority of the women (58%) did not know that their partner(s) were HIV positive. This could mean that men engage in unprotected intercourse more than women and women are not able to make sole decision on safe sexual practice.

5.4 Information disclosure on HIV status

All the respondents have been counselled by health workers. The level of disclosure by both men (65%) and women (83%) recorded in this study may be due to the effectiveness of the counselling services.

5.4.1 Age

The study revealed that disclosure occurs more regularly with age and was highest in the middle age group for both men and women. Disclosure was 52.1% in men in the age group 30-50 years and 80.5% in women of the same age group. Disclosure was lowest in the below 30 years age group in both men and women. Nevertheless, disclosure is still higher in women than men.

5.4.2 Education

The study showed that the higher the level of education, the higher the disclosure for both men and women. In this category, disclosure was higher in men (77%) with secondary education and above than women (62.5%) with the same level of education. Therefore, level of education seems to influence disclosure positively in both men and women.

5.4.3 Income

Disclosure was highest in men earning more than 5000 Pula (34.4%) in contrast to the highest in Women (37.2%) in less than 2500 Pula category. In terms of income, women with low income seem to disclose more often while men with high income disclose less.

5.4.4 Marital status

The study shown that in women, disclosure was 76.4% and 14.7% among the married/co-habiting. Disclosure was 66.6% in single men and 13.3% in married/co-habiting. Disclosure was highest among singles for both men and women. The findings are consistent with the findings that majority of adults in Botswana are not married (Botswana AIDS Impact Survey III).

5.4.5 Occupation

Disclosure was greater among the employed with 73% and 71% in men and women respectively. Disclosure was low among the unemployed for both men and women. Therefore, it seems that socio-economic status influences disclosure of HIV status.

5.4.6 Household size

The study showed that disclosure was highest among men and women with household size of 1-3 people having 32.1% and 45.2% respectively. Disclosure was low among the larger household size possibly due to fear that confidentiality will not be guaranteed beyond the household as family members may disclose to their friends.

5.5 Who did the respondents disclose to?

The study showed that 14% of men and 21% of women disclosed to their spouse. 36% men and 41% women disclosed to their relatives while 41% men and 33% women disclosed to casual sexual partner. Nine percent of men disclosed to friend(s) while 5% of women disclosed to friend(s). The findings are consistent with the study by Korte et al, (2004) with 71% disclosure to sexual partner and 90% disclosure to family members.

5.6 Disclosure determinants

5.6.1 I see no need to divulge information on my HIV status

In the study, 31% of men agreed, 52% disagreed while 39% of women agreed and 56% disagreed. The findings contrasts the study of Linda et al, 2006 where it was stated that many people do not consider it necessary to disclose their HIV status.

5.6.2 I do not like to be treated as an outcast by the society. As such I did not disclose the information on my HIV status

Sixty percent of men agreed while 27% disagreed. 39% of women agreed while 52% disagreed. Thus, women seem more likely to disclose in the face of discrimination than men. This study concurs with Kassaye et al, 2005 that many individuals may not disclose their HIV status due to discrimination.

5.6.3 I am afraid of what people would think about me if I disclose information on my HIV status

Fifty-three percent of men agreed while 27% disagreed. Thirty percent of women agreed and 56% disagreed. Thus, women seem more likely to disclose in the face of stigma than men.

5.6.4 I disclosed information on my status as soon as I realised I got infected with HIV

Forty-two percent of men agreed and 48% disagreed. Sixty-eight percent of women agreed while 23% disagreed. Hence, women seem more likely to disclose their HIV status earlier than men. Early disclosure is of utmost importance in prevention because it promotes safe sexual behaviour (Lauretta et al, 2011).

5.6.5 There is no reason why information should not be disclosed because I see HIV infection and its associated symptoms just as any other disease(s)

Thirty-three percent of men agreed and 64% disagreed. Forty-eight percent of women agreed while 45% disagreed. Hence, women seem more likely to disclose their HIV status than men. Poor disclosure in men increases the risk of HIV infection in women (Keogh et al, 1994).

5.6.6 I disclosed the information about my status to prevent me from spreading the ailment

Fifty-two percent of men agreed, 48% disagreed. Eighty percent of women agreed while 18% disagreed. The study also showed that women disclose more than men. This reinforces the fact that the level of awareness in women is higher than in men (Lauretta et al, 2011).

5.6.7 Not disclosing the information on my HIV status would amount to carrying heavy burden all alone

Forty-one percent of men agreed and 41% disagreed. Fifty-seven percent of women agreed while 30% disagreed. Therefore, women seem to be more emotional and as such could not withstand the burden of HIV alone, therefore disclose more than men.

5.6.8 I disclose the information on my HIV status so that I could receive help and quality advice from health workers/experts

In this study, 46% of men agreed and 43% disagreed. Eighty-one percent of women agreed while 19% disagreed. Women also disclose to the health workers more than men. Therefore, it seems the majority of men find it difficult to disclose their HIV status to health workers.

5.6.9 I disclosed information on my HIV because I want my experience to teach uninfected individuals a lesson

Fifty-two percent of men agreed and 38% disagreed. Sixty-five percent of women agreed while 26% disagreed. Women disclose their HIV status more than men just to teach others so that they will learn from them. From this finding, it seems that women might be better at helping others understand why it is important to know and disclose their HIV status compared to men.

5.6.10 I disclosed my HIV status because I could not hide my medications from my partner/friends/relatives

Thirty-eight percent of men agreed and 55% disagreed. Forty-nine percent of women agreed while 49% also disagreed. Women seem more likely to disclose their HIV status compare to men because they could not hide their medications from people around them. Poor adherence is a possibility among men who would not disclose their status but continue to take their medications secretly. Women could therefore be more likely to have good adherence to antiretroviral therapy than men.

5.6.11 I disclosed my HIV status when I was seriously ill

In this study, 26% of men agreed and 74% disagreed. Fifteen percent of women agreed while 78% disagreed. The study showed that this is the only situation that made men to disclose more than women. It seemed that men only disclosed when all avenues to hide their HIV status failed and mostly when they seriously ill.

5.6.12 I disclosed my HIV status because my friends disclosed their status

Twenty-three percent of men agreed and 70% disagreed. Sixteen percent of women agreed while 79% disagreed. The study showed that peer pressure seems to be a determinant of HIV disclosure. Men disclose their status more in this category because the status of their friend(s) was known.

5.6.13 I disclosed my HIV status because people are suspicious of my frequent hospital/clinic visits

The study shows that 33% of male agreed and 60% disagreed. Nineteen percent of women agreed while 71% disagreed. Men disclosed more than women because of the hospital visit they could not keep secret. Therefore, it could be that frequent hospital visits may lead to poor adherence to drugs so as to prevent people from knowing their HIV status.

Chapter 6: Conclusion and Recommendations

6.1 Conclusion

The study showed that disclosure was generally higher among women compare to disclosure among men.

Men found it more difficult to disclose their HIV status even when is at the detriment of their health compare to women. Disclosure to health workers was also low among men which may prevent them from receiving quality care. Women disclosed more than men across all demographic characteristics (age, level of education, income, occupation, marital status and household size), and in the presence of stigma and discrimination. Men seemed to keep their status secret rather than to disclose or get help. The study revealed that women more than men seemed to disclose their status in order to relieve themselves of the burden of being HIV positive and as such get quality care from health workers.

Men disclosed more often than women in the event that they could not hide their medication from partners/relatives, critically ill and when people are suspicious of their frequent hospital visits. In all of these scenarios, disclosing may be too late to achieve its purpose because of poor adherence and unsafe sexual intercourse which makes women to be more vulnerable to HIV infection.

Disclosure was highest among the middle age group (30-50 years) in both male and female respondents. The intensive efforts of the Botswana government in HIV prevention and care seem therefore that it is yielding positive results. This group represents the workforce of the country and is also sexually active. Therefore, achieving 100% disclosure is desirable to ensure safer sexual intercourse.

In this study, sexual intercourse was reported as the most frequent mode of HIV transmission, followed by the use of sharp unsterilized objects. Hence, emphasis

should be on safe sexual practice during voluntary counseling and testing for both concordant and disconcordant partners. Though, it is difficult for individuals to know with any degree of accuracy, the mode through which they were infected. However, the findings are the perceived mode of infection of the respondents.

Respondents with smaller household sizes (number of people) disclosed more frequently than those with large household sizes. Fear that confidentiality cannot be maintained among all the household members may be the reason for this finding. It could also be that the respondents were of the opinion that their relatives will tell others and gossip to the community in which they live.

The study also showed that men disclosed more often than women in the situations in which the former were seriously ill, when their peer (friends) disclosed their status or when they could no longer keep their hospital visits secret.

6.2 Recommendations

The following recommendations were made based on the findings of the study

6.2.1 Conduct more research

Men disclosed more than women when they could not keep their medications secret. This could mean that there is a relationship between adherence and disclosure. Therefore, there is need to conduct further research on the influence of disclosure on adherence to antiretroviral therapy.

6.2.2 Men targeted awareness programmes

The level of awareness on HIV/AIDS was seemingly lower among men which may be partly responsible for the lower disclosure rate among men. Men therefore need to be sensitized on the issue of HIV. HIV/AIDS awareness and counseling could be introduced into the SAFE MALE CIRCUMCISION (SMC) programmes in Botswana.

6.2.3 There is need for universal education

In this study, higher level of education connotes higher frequency of disclosure. Therefore, government should ensure that her citizens are well educated as this could stem the spread of HIV infection.

6.2.4 There is need for economic empowerment

Disclosure was also more frequent among the employed than unemployed as recorded in this study. Therefore, creation of more jobs and economic empowerment of individuals could reduce the spread of HIV infection.

6.2.5 Peer group education

In this study, men disclosed more when friends disclosed their status. Therefore, peer group education could be an effective way of achieving greater percentage of disclosure among people living with HIV.

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Appendixes

INFORMATION SHEET

Dear Respondent/Participant

Re: A Comparative Analysis of HIV-Serostatus Disclosure Pattern Among

Men and Women in Gaborone City Council, Botswana

In partial fulfillments of the requirements of the Master of Philosophy Degree in HIV/AIDS Management from the Africa Center of HIV/AIDS Management at Stellenbosch University. I am carrying out a study with the above title. I am a medical practitioner presently working at the infectious disease unit of Bokamoso Hospital, Gaborone. The information you will supply is for academic purposes and will be treated with utmost confidentiality. Participation is voluntary and completing and dropping the Questionnaire in the box provided implied consent. I am available to answer any question and concern while the questionnaire is being completed. A clinical psychologist is also available to deal with any psychological trauma arising from completing the questionnaire.

The purpose of this study was to gather baseline information on the factors favouring and those preventing men and women from disclosing their HIV status.

The aim of the studyis to compare the patterns of HIV-serostatus disclosure among men and women in Gaborone City Council and integrate the findings into pre and post-test counselling services

The study objectives are as follows:

1. To determine the factors that influence HIV-serostatus disclosure by men and women.

2. To find measures that can be used to break the gender differences in HIV-serostatus disclosure among men and women
3. To compare and contrast the outcomes with results from other developing countries.
4. To suggest to the authority concerned to incorporate the recommendations based on the findings into the HIV pre and post-test counselling services/programmes

Please feel free to contact me should you have any questions or you need clarification.

Thank you.

Yours sincerely

Dr Oladimeji Akeem, AKINYEMI

INFORMATION SHEET IN SETSWANA

Go motsayakarolo/ moarabi

RE: TSHWANTSHANYO YA SEEMO SA MOGARE WA HIV KA BA BA TSWELANG MO PONTSHENG MO GO BORRE LE BOMME MO KHANSELENG YA GABORONE, BOTSWANA.

Mo maikemisetsong a atsepameng a tse di tlhokafalangmodithutegongtse di kwagodimo-dimotsapatlisisokamogarewa HIV le botsamaisi (Master of Philosophy Degree in HIV) go tswamolekalaneng la botsamaisi la Africa Centre of HIV/AIDS kwammadikolowa Stellenbosch.

Kedirathutisokasetlhogo se sefagodimo.Kemongwewababotsogoyo o berekelangkwalekalaneng la malwetsi a atshelanwangkwakokelongya Bokamoso mo Gaborone. Molaetsa o lo tla o abang o diretswedithutotsasekolo gape o tla a tsewakasephiri se setseneletseng. Moonowathutiso e, e ne e le go batlisisakitso go tswakwamodingkamabaka a abagwetlhang le a akganelangborre le bomme go tswelamopontshengkaseemosamogarewa HIV.

Maikaelelo a thutiso e ke go tshwantshanyaseemosa go tswelamopontshengkamogarewa HIV mo go borre le bommemokhanselengya Gaborone le go amanyamaduo a motshidilomaikutlongpele le moragogaditirelo.

MAIKEMISETSO A THUTISO A LATELA JAANA:

1. Go itebaganya le mabakaaarotloetsang go tswelamopontshenggaborre le bomme.
2. Go batladitselatse di kakgaolangpharologanyoya bong mo go tswelengmopontshengmagarenggaborre le bomme.
3. Go amanya le go farologanyaditlamoragotsamaduo go tswamomafatsheng a mangweaatlhabologang.

4. Go tshwaelamo go babaamegangbana le boikarabelo e le go tlhakantshamaduo a ditshwetso go lebeletswemaduo a tshidilomaikutlokamogarewa HIV pele le moragogaditirelo/ mananeo.

Tsweetsweegololesega go kaikopanya le nnafa o katswa o na le dipotso kana o batlatlhalosonngwe.

Ke a leboga

Kaboikokobetso

Dr. Oladimeji Akeem, AKINYEMI

English Questionnaire

I'm OLADIMEJI AKEEM AKINYEMI, a postgraduate student of Stellenbosch University. This questionnaire is for collection of data on the title below:

"A comparative analysis of HIV *serostatus* disclosure pattern among men and women in Gaborone City Council"

Your sincere answers are very important and confidentiality is guaranteed. Participation is voluntary and completing the questionnaire and depositing it in the box provided will be regarded as implied consent. You can skip any question you are not willing to answer.

Thank you.

Demographic and socio-economic information

1. Location [Village/District]: ……

2. Sex: Male [ ][1]; Female [ ][2]; Observe and check the appropriate box.

3. Age: How old are you? [Check the appropriate box]

Below 26 years [ ][1]; Between 26-30 years [ ][2]; 31-35 years [ ][3]; 36-40 years [ ][4]; 41-45 years [ ][5]; 46-50 years [ ][6]; 51- 55 years [ ][7]; 56- 60 years [ ][8];

4. Marital status: [Check the appropriate box]

[iii] single living with sexual partner [ ][1]

[iv] single not living with sexual partner [ ][2]

[v] single with no sexual partner [ ][3]

[i] married living with spouse [ ][4]

[ii] married not living with spouse [ ][5]

[vi] divorced living with sexual partner [ ][6]

[vii] divorced not living with sexual partner [ ][7]

[viii] divorced with no sexual partner [ ][8]

5. Education level: What is your level of education? Check the appropriate box below:

[i] I had no formal or non-formal education [ ][0]

[ii] I attended adult literacy class [ ][1]

[iii] I attended primary education but never finished it [ ][2]

[iv] I had standard seven leaving certificate [ ][3]

[v] I attended secondary education but never finished it [ ][4]

[vi] I had Seondary School Certificate [ ][5]

[vii] I had post-secondary education [ ][6]

6. Occupation: What are your means of livelihood? Check the appropriate box below:

[i] I engage in trading [ ][1]

[ii] I am a civil servant [ ][2]

[iii] I'm involved in artisan work [ ][3]

[iv] I'm a farmer [ ][4]

[v] I engage in cattle rearing [ ][5]

[vi] Others ……[6]

7. Income level: How much in total do you earn per month in Batswana Pula [BWP}[1]? Check the appropriate box below:

[i] Below BWP 2, 500 [ ][1]

[ii] Between 2, 501 – 5, 000 [ ][2]

[iii] Between 5, 001 - 7, 500.00 [ ][3]

[iv] Between 7, 501.00 – 10,000.00 [ ][4]

[v] Between 10,001.00 – 12, 500.00 [ ][5]

[vi] Between 12, 501.00 – 15, 000.00 [ ][6]

[vii] Between 15, 001.00 – 17, 500.00 [ ][7]

[viii] Between 17, 501.00 – 20, 000.00 [ ][8]

[ix] Between 20, 001.00 – 22, 500.00 [ ][9]

[x] Between 22, 501.00 – 25, 500.00 [ ][10]

[xi] Above 25, 000.00 [ ][11]

8. Household size: How many people live with and depend on you on a day-to day basis? Check the appropriate box below?

[i] I am the only person living under the same roof [ ][1]

[ii] Between 2 – 3 people[2]

[iii] Between 4 – 5 people[3]

[1] US$1.00 is the equivalent of BWP 6.50

[iv] Between 6 – 7 people[4]

[v] Between 8 – 9 people[5]

[vi] Above 9 people[6]

9. Contact with health [extension] workers [both private and public]: How many times have you had contact with and receive counsels from healthcare personnel? Check the appropriate box below:

[i] None [ ][0]; [ii] Once [ ][1]; [iii] Twice [ ][2]; [iv] Three times [ ][3]; More than three times [ ][4]

10. Medium through whichHIV was contracted

a.Indicate how you got infected with HIV.

[i] I got infected through sexual intercourse [ ]

[ii] I got infected through sharp objects during shavings, barbing, manicure or hair dressing [ ]

[iii] I got infected through oral sex [ ]

[iv] I got infected through bith [ ]

[v] I do not know how I got infected [ ]

[vi]Others

.....
.....

11. Awareness about HIV/AIDS before contracting the disease

a. Were you aware of the HIV/AIDS before you contract the ailment? Yes [ ]; No [ ]

b. If 'YES' to 'a' above, why did you not prevent it before it happened?

[i] I never believed it could happen [ ]

[ii] I just could not restrain myself [ ]

[iii] I did try to prevent it through the use of condom but I still contracted it [ ]

[iv] Others ----------

12. Information disclosure on HIV status

a. Have you disclosed your HIV status? Yes [ ]; No [ ]

b. If 'YES' to 'a' above, to whom did you disclose? You can check more than one box

[i] spouse [ ]

[ii] co-habiting sexual partner [ ]

[iii] casual sexual partner [ ]

[iv] friend [ ]

[v] relatives [ ]

[vi] others…….

c. Respond to the following statements below as to whether you strongly agree [SA]; agree [A]; undecided [U]; disagree [D]; and strongly disagree [SD] with them. Please, read to respondent [if non-literate] and check the appropriate box/answer based on the strength of his or her affirmation or otherwise:

SN	Statement	[5]SA	[4]A	[3]U	[2]D	[1]SD
i	Living with HIV is enough trauma to disclose the information to people					
ii	The stigma attached to the ailment by the society discouraged me from divulging information about my status					
iii	I see no need to divulge information on my HIV status					
iv	I do not like to be treated as an outcast by the society. As such I did not disclose the information on my HIV status					
v	I am afraid of what people would think about me if I disclose information on my HIV status					
vi	I have disclosed information on my staus as soon as I realised I got contracted with the ailment					
vii	There is no reason why information should not be disclosed because I see HIV infection and its associated symptoms just as any other disease (s)					
viii	I disclosed the information about my status to prevent me from spreading the ailment					
ix	I disclosed information on my HIV status because that is the only way I could live peacefully with myself and others					
x	Not disclosing the information on my HIV status					

	would amount to carrying heavy burden all alone.					
xi	I disclose the information on my HIV status so that I could receive help and quality advice from health workers/experts					
xii	I disclosed information on my HIV status because I want my experience to teach uninfected individuals a lesson.					
xiii	I disclosed my HIV status because I could not hide my medications from my partner/friends/ relatives					
xiv	I disclosed my HIV status when I was seriously ill					
xv	I disclosed my HIV status because people are suspicious of my frequent hospital/clinic visits					
xvi	I disclosed my HIV status because my friends disclosed their status					

QUESTIONNAIRE IN SETSWANA

POTSOLOTSO

Kenna **OLADIMEJI AKEEM AKINYEMI** sealoganesa Stellenbosch University. Potsolotso e ediretswe go batlakitsokadintlhatsedifatlase:

'TSHWANTSHANYO YA SEEMO SA MOGARE WA HIV KA BA BA TSWELANG MO PONTSHENG MO GO BORRE LE BOMME MO KHANSELENG YA GABORONE"

Bonnete le boammarurijwadikarabotsagagobobotlhokwafelathata. Re go tshepisa go bayatsotlhe e le phitlhela. O katlogelapotso e nngwe le e nngwefa o sakgone go e araba. Go tsayakarolomopotsolosong e keboikgethelo. Go feleletsapotsoloso e le go e romelamolebokosong go tla a tsewa e le tumalano eetsepameng. Ke a leboga.

PEGO YA PALO YA BATHO LE ITSHOLELO YA SELEGAE (DIEMO TSE DI SA LAOLESEGENG)

1. LEFELO (Motse, kgaolo)……
2. BONG: RRE( )[1] MME ( )[2]; elatlhokolebokoso le lesiameng.
3. DINGWAGA: O dingwaga di kae? (lebelelalebokoso le lesiameng)
   [i] Kwatlasegadingwagatse di masomemabedi -borataro ( )[1]
   [ii] Fagaregadingwagatse di masomemabedi le borataro -masome a mararo( )[2]
   [iii] Masome a mararo le bongwe –masome a mararo le botlhano ( )[3]
   [iv] Dingwagatse di masome a mararo le borataro –masome a mane ( )[4]
   [v] Dingwagatse di masome a mane le motso –masome a mane le btlhano ( )[5]
   [vi] Dingwagatse di masome a mane le borataro- masome a matlhano ( )[6]
   [vii] Dingwagatse di masome a matlhano le motso – masome a matlhano le botlhano ( )[7]
   [viii] Dingwagatse di masome a matlhano le borataro- masome a marataro( )[8]

4. SEEMO SA TSEO (lebelelalebokoso le lesiameng)

[i] Gake a nyalwammekenna le mokapelo ( )[1]

[ii] Gake a nyalwaebilegakenne le mokapelo ( )[2]

[iii] Kenyetse/ nyetsweebilekenna le mokapelo ( )[3]

[iv] Kenyetse/nyetswemmega ken ne le mokapelo ( )[4]

[v] Ketlhadilwe/tlhadile mm eke nna le mokapelo ( )[5]

[vi] Ketlhadilwe/ tlhadilemmega ken ne le mokapelo ( )[6]

[vii] Ketlhadilwe/ tlhadileebilegakenamokapeko ( )[8]

5. SEEMO SA THUTO: O rutegile go le kae? Lebelelalebokoso le lesiamengfatlase:

[i] Gake a rutega ( )[0]

[ii] Ketsenesekolosagaegolelwe ( )[1]

[iii] Ketsenesekolo se sebotlanammegake a se fetsa ( )[2]

[iv] Kena le setlankanasalokwalolwabosupa ( )[3]

[v] Ketsenesekolo se segolwanemmegake a se fetsa ( )[4]

[vi] Kena le setlankanasasekolo se segolwane ( )[5]

[vii] Kena le setlankanasamophatowabofelo ( )[6]

6. PEREKO: O itshetsakaeng? Lebelelalebokoso le lesiamengfatlase:

[i] Ke a rekisa ( )[1]

[ii] Kemodirelapuso ( )[2]

[iii] Kediratiroyadiatla ( )[3]

[iv] Kemolemi ( )[4]

[v] Kemorui ( )[5]

[vi] Tsedingwe ( )[6]

7. DIPOELO: O diradipoelotsabokaekakgwedikaledi la Pula (BWP)? Lebelelalebokosole lesiameng ha tlase:

[i] Kwatlasega BWP 2,500 ( )[1]

[ii] Fagarega 2,501- 5000 ( )[2]

[iii] Fagarega 5,001- 7,500 ( )[3]

[iv] Fagarega 7,501- 10,000 ( )[4]

[v] Fagarega 10,001- 12,500 ( )[5]

[vi] Fagarega 12,501- 15,000 ( )[6]

[vii] Fagarega 15,001- 17,500 ( )[7]

[viii] Fagarega 17,501- 20,000 ( )[8]

[ix] Fagarega 20,001- 22,500 ( )[9]

[x] Fagarega 22,501- 25,000 ( )[10]

[xi] Go feta 25,000 ( )[11]

8. BOTONA JWA LELWAPA: Kebathoba le kaeba o nnang le bone e bile batlhokatlhokomeloyagagomalatsiotlhe? Lebelelalebokoso le lesiamengfatlase.

[i] Kennake le nosi ( )[1]

[ii] Fagaregabathobababedi le boraro ( )[2]

[iii] Fagaregabathoba le bane le botlhano ( )[3]

[iv] Fagaregabathoba le barataro le bosupa ( )[4]

[v] Fagaregabathoba le boferabobedi le boferabongwe ( )5

[vi] Go feta boferabongwe ( )[6]

9. BOKOPANO LE BA LEPHATA LA BOTSOGO (TSE DI IKEMETSENG LE TSA SECHABA): Lebelelalebokoso le lesiameng:

[i] Gankemokgweding ( )[0]

[ii] Gangwemokgweding ( )[1]

[iii] Gabedimokgweding ( )[2]

[iv] Gararomokgweding ( )[3]

[v] Go feta gararomokgweding ( )[4]

10. DITSELA TSE MOGARE WA HIV O KA TSHELWANG KA TENG: Supakafa o tsenwengkemogarewa HIV kateng:

[i] Ketsenwekemogarewa HIV katlhakanelodikobo ( )

[ii] Ketsenwekemogarekatirisodidirisiwatse di bogalenako yak e beola, kebaakanyadinalakgotsakediramoriri ( )

[iii] Ketsenwekemogarekatlhakanelodikoboyalegano ( )

[iv] Ketsenwekemogarenakoyapelegi ( )

[v] Gakeitse go re ketsenwekemogarejang ( )

[vi] Ditselatsedingwe ( )……..

11. KITSO KA MOGARE WA HIV / AIDS PELE GA O TSENWA KE MOGARE

A) A o ne o itsekabodiphatsajwamogarewa HIV/AIDS pelegatshwaetso?
EE ( ): NNYAYA ( )

B) Fa e le EE fa "A" fagodimo, keengo ne o sathibelepelega o go tsenafa e le gore o go tsenekatlhakanelodikobo?

[i] Ke ne kesadumele gore go tlaadirega ( )

[ii] Ke ne kesakgone go ikgapha ( )

[iii] Kelekile go dirisasakausummewantsenafela ( )

[iv] Ditselatsedingwe ( )……..

12. KITSO KA GO TSWELA MO PONTSHENG KA SEEMO SA MOGAREWA HIV

A) A o tswetsemopontshengkaseemosagagosamogarewa HIV?
EE ( ): NNYAYA ( )

B) Fa o arabilepotso e efagodimo o re 'EE', o boleletsemang? Lebelelalebokoso le feta bongwe.

[i] Mokapelo ( )

[ii] Rre/Mmeyoketshelang le enemme re sanyalana ( )

[iii] Rre/Mmeyo re thusanangmogotsatlhakanelodikobokanakwana ( )

[iv] Tsala ( )

[v] Losika ( )

[vi] Babangwe ( )……..

Dintlhatsa go tswelamopontshengkaseemosamogarewaHIV(seemo se selaolesegang)

Arabadielatse di latelang go yakago:

Dumelathata (DT)

Dumela (D)

Gagodumalanwe (GD)

Gagonatshwetso e etserweng (GT)

Gagodumalanwegotlhelele (GDT)

Katsweetsweebolelelamoarabi (fa a sarutega) a bo o lebelelelebokoso le lesiameng. Araba o remeletsemoboketengjwatumalanoyagagwe (rre/mme) kana katsela e sele:

SN	DINTLHA	DT	D	GD	GT	GDT
1	Go tshelakamogarewa HIV keletshogo le lekwagodimo le o ka se bolelelengbatho					
2	Go kgetholowagababaamilwengkemogarewa HIV go nkiditse go ntshetsaseemosa me samogarekwantle					
3	Ke bona go senamosola go ntshetsaseemosa me samogarekwantle					
4	Gake rate go tsewajaakamoitaodikebathobamotsekajalogake a bolelelabathokaseemo same samogare					
5	Ketshaba gore bathobatla a rengkannafakebuakaseemosa me sa HIV					
6	Ke ne kebuakaseemosa me samogarewa HIV felafakesena go lemoga gore ketsenwekebolwetse					
7	Gagonalebaka la gore go sekagabuiwakaseemo se ka					

	gore ke bona go tsenwakemogarewa HIV le dikaitse di amanang le o ne go tshwanafela le malwetse a mangwe					
8	Ketswetsemopontshengkaseemosa me samogarewa HIV go kganela go anamisabolwetse					
9	Ketswetsemopontshengkaseemosa me samogarewa HIV ka gore keyonetsela e nkatshelangkakagiso le babangwe.					
10	Go tlhoka go tswelamopontshengkaseemosa me samogarewa HIV go kankimelagannamokgweleo o kaboo ne o kafelela o kampolaya					
11	Ketswetsemopontshengkaseemosa me samogarewa HIV gore kekgone go bona thuso le bogakolodimo go batsabotsogo le baitsaanape.					
12	Ketswetsemopontshengkaseemosa me samogarewa HIV gore kakitsoya me kekgone go rutababangwebabaisengbatsenwekemogare					
13	Ketswetsemopontshengkaseemosa me samogarewa HIV ka gore ke ne kesakgone go fitlhelamokapelo/ tsala/ lesikadipilisitsadiritibatsi					
14	Ketswetsemopontshengkaseemosa me samogarewa HIV fake ne kegateletswekebolwetse					
15	Ketswetsemopontshengkaseemosa me samogarewa HIV ka gore bathoba ne bana le dipelaeloke go etelaga me babongakakgapetsakgapetsa					
16	Ketswetsemopontshengkaseemosa me samogarewa HIV ke gore ditsalatsa me di ne di tswetsemopontshengkadiemotsa bone					

Approval Letter from the GDHMT

TELEPHONE: (267) 3133658
FAX : (267) 3907950
REFERENCE : DHMT

REPUBLIC OF BOTSWANA

Gaborone District Health Management
PRIVATE BAG 00258
GABORONE
BOTSWANA

Ref: DHMT

Dr. Oladimeji Akeem Akinyemi
PO Box 70120
Gaborone

13th, September, 2012

Dear sir/Madam

RE: Permission to conduct Study in Gaborone Public Clinics

Reference is made to your letter of request dated 12th, September, 2012.

This serves to let you know that permission is granted to conduct **a comparative analysis of HIV sero-status disclosure pattern among men and women in Gaborone clinics.**

This permits you to go into the health facility but you need to ask respondents for their participation. It should also not disturb patient care in any manner during the course of the visit.

The facilities allocated are all ARV clinics in Gaborone.

By copy of this letter the ARV site manager, Matrons and Nurse In-charges of the Health facilities are informed of your intentions.

Thank you.

Yours faithfully,

Dr. A. Libse
Coordinator DHMT/Public Health Specialist

GABORONE DHMT
PRIVATE BAG 0089, GABORONE
1 3 SEP 2012
TEL: 3653521 / 3974468
PUBLIC HEALTH SPECIALIST

Furthermore, you are requested to submit at least one hardcopy and an electronic copy of the report to the Health Research, Ministry of Health within 3 months of completion of the study. Copies should also be submitted to all other relevant authorities.

If you have any questions please do not hesitate to contact Mr. P. Khulumani at pkhulumani@gov.bw, Tel +267-3632607 or Lemphi Moremi at lamoremi@gov.bw Tel: +267-3632754

Continuing Review
In order to continue work on this study (including data analysis) beyond the expiry date, submit a Continuing Review Form for Approval at least three (3) months prior to the protocol's expiration date. The Continuing Review Form can be obtained from the Health Research Division Office (HRDD), Office No. 9A 10 or Ministry of Health website: www.moh.gov.bw or can be requested via e-mail from Mr. Kgomotso Motlhanka, e-mail address: kgmmotlhanka@gov.bw As a courtesy, the HRDD will send you a reminder email about eight (8) weeks before the lapse date, but failure to receive it does not affect your responsibility to submit a timely Continuing Report form.

Amendments
During the approval period, if you propose any change to the protocol such as its funding source, recruiting materials, or consent documents, you must seek HRDC approval before implementing it. Please summarize the proposed change and the rationale for it in the amendment form available from the Health Research Division Office (HRDD), Office No. 9A 11 or Ministry of Health website: www.moh.gov.bw or can be requested via e- mail from Mr. Kgomotso Motlhanka, e-mail address: kgmmotlhanka@gov.bw . In addition submit three copies of an updated version of your original protocol application showing all proposed changes in bold or "track changes".

Reporting
Other events which must be reported promptly in writing to the HRDC include:
- Suspension or termination of the protocol by you or the grantor
- Unexpected problems involving risk to subjects or others
- Adverse events, including unanticipated or anticipated but severe physical harm to subjects.

Do not hesitate to contact us if you have any questions. Thank you for your cooperation and your commitment to the protection of human subjects in research.

Yours sincerely

P. Khulumani
For Permanent Secretary

MINISTRY OF HEALTH
DEPT. OF POLICY PLANNING, MONITORING AND EVALUATION
26 JUL 2012
P/BAG 0038
GABORONE
REPUBLIC OF BOTSWANA

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